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NEW CARE MODELS:

Vanguards - developing a blueprint for
the future of NHS and care services



SEPTEMBER 2016

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WHAT IS THE NEW CARE MODELS PROGRAMME?

In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme, one of the first steps towards delivering the [NHS Five Year Forward View](#) (published October 2014) and supporting improvement and integration of services.

In March 2015, [the first 29 vanguards](#) were chosen. There were three vanguard types – integrated primary and acute care systems; enhanced health in care homes; and multispecialty community providers.

Integrated primary and acute care systems join up GP, hospital, community and mental health services, whilst multispecialty community providers move specialist care out of hospitals into the community. Enhanced health in care homes offer older people better, joined up health, care and rehabilitation services.

In late July 2015, [eight additional vanguards](#) were announced. Urgent and emergency care vanguards are developing new approaches to improve the coordination of services and reduce pressure on A&E departments.

[A further 13 vanguards](#) were announced in September 2015 – known as acute care collaborations, they aim to link hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

All 50 vanguards were selected following a rigorous process, involving workshops and the engagement of key partners and patient representative groups.

Each vanguard is taking a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

What does it mean for patients?

The vanguards are improving the care received by millions of people across England.

Through the new care models programme, complete redesign of whole health and care systems are being considered. This means fewer trips to hospitals with cancer and dementia specialists holding clinics in local surgeries, having one point of call for family doctors, community nurses, social and mental health services, or access to blood tests, dialysis or even chemotherapy closer to home.

They are also joining up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that patients know where they can get urgent help easily and effectively, seven days a week.

The partners

The new care model vanguards are a key element within the [NHS Five Year Forward View](#) which is a partnership between NHS England, the Care Quality Commission, Health Education England, NHS Improvement, Public Health England and the National Institute for Health and Care Excellence.

Supporting the vanguards

The NHS Five Year Forward View partners published an updated national support package for all 50 vanguards in December 2015.

This followed an initial support package, which was published in July 2015 for the first 29 vanguards.

The revised package reflects the needs of the eight urgent and emergency care and 13 acute care collaboration vanguards selected in July and September 2015. It includes learning to date from the first 29 vanguards.

Extensive engagement with the vanguards was carried out including site visits, workshops and discussions.

The nine areas of support are:

- 1. Designing new care models** – working with the vanguards to develop their local model of care, maximising the greatest impact and value for patients;
- 2. Evaluation and metrics** – supporting the vanguards to understand – on an ongoing basis – the impact their changes are having on patients, staff and the wider population;
- 3. Integrated commissioning and provision** – assisting the vanguards to break down the barriers which prevent their local health system from developing integrated commissioning;

- 4. Governance, accountability and provider regulation** – helping the vanguards develop the right organisational form and governance model, as well as understand the impact on how they are regulated;
- 5. Empowering patients and communities** – working with the vanguards to enhance the way in which they work with patients, local people and communities to develop services;
- 6. Harnessing technology** – supporting the vanguards to rethink how care is delivered, given the potential of digital technology to deliver care in radically different ways. It will also help organisations to more easily share patient information;
- 7. Workforce redesign** – supporting the vanguards to develop a modern, flexible workforce which is organised around patients and their local populations;
- 8. Local leadership and delivery** – working with the vanguards to develop leadership capability and learn from international experts; and
- 9. Communications and engagement** – supporting the vanguards to demonstrate best practice in the way they engage with staff, patients and local people.

The national package has been developed to enable the vanguards to make the changes they want effectively and at pace. It is also aims to maximise the sharing of learning across the vanguards and spread good practice nationally across the wider NHS and care system.

In addition to the support outlined in the support package the 50 vanguards were allocated total funding of almost £114 million in 2015/16 and more than £112 million in 2016/17.

NEW CARE MODELS - the vanguards

Integrated primary and acute care systems - joining up GP, hospital, community and mental health services

- 1 Wirral Partners
- 2 Mid Nottinghamshire Better Together
- 3 South Somerset Symphony Programme
- 4 Northumberland Accountable Care Organisation
- 5 Salford Together
- 6 Better Care Together (Morecambe Bay Health Community)
- 7 North East Hampshire and Farnham
- 8 Harrogate and Rural District Clinical Commissioning Group
- 9 My Life a Full Life (Isle of Wight)

Multispecialty community providers - moving specialist care out of hospitals into the community

- 10 Calderdale Health and Social Care Economy
- 11 Wellbeing Erewash
- 12 Fylde Coast Local Health Economy
- 13 Modality Birmingham and Sandwell
- 14 West Wakefield Health and Wellbeing Ltd
- 15 All Together Better Sunderland
- 16 Dudley Multispecialty Community Provider
- 17 Encompass (Whitstable, Faversham and Canterbury)
- 18 Stockport Together
- 19 Tower Hamlets Together
- 20 Better Local Care (Hampshire)
- 21 West Cheshire Way
- 22 Lakeside Healthcare (Northamptonshire)
- 23 Principia Partners in Health (Southern Nottinghamshire)

Enhanced health in care homes - offering older people better, joined up health, care and rehabilitation services

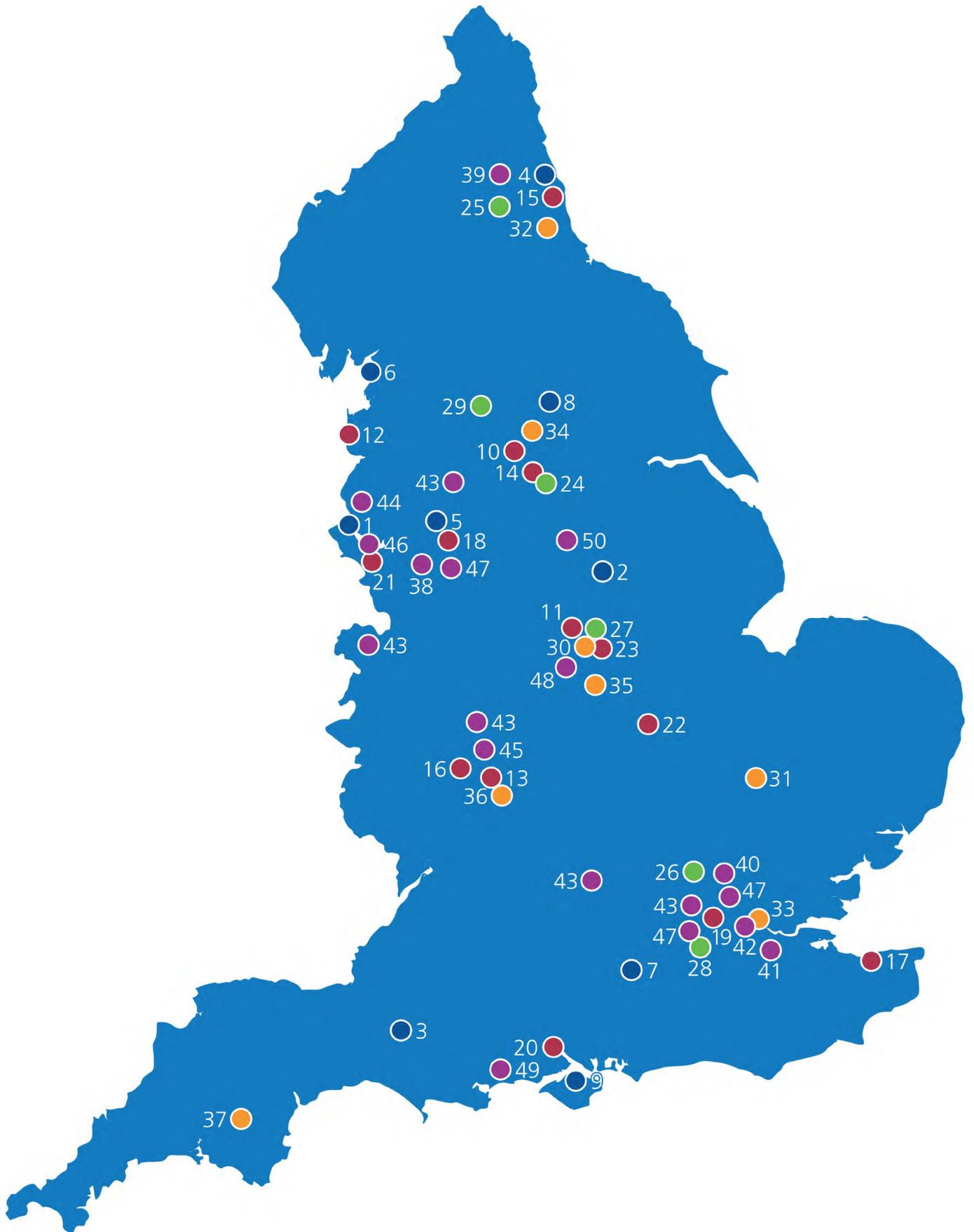
- 24 Connecting Care - Wakefield District
- 25 Gateshead Care Home Project
- 26 East and North Hertfordshire Clinical Commissioning Group
- 27 Nottingham City Clinical Commissioning Group
- 28 Sutton Homes of Care
- 29 Airedale & Partners

Urgent and emergency care - new approaches to improve the coordination of services and reduce pressure on A&E departments

- 30 Greater Nottingham System Resilience Group
- 31 Cambridgeshire and Peterborough Clinical Commissioning Group
- 32 North East Urgent Care Network
- 33 Barking and Dagenham, Havering and Redbridge System Resilience Group
- 34 West Yorkshire Urgent and Emergency Care Network
- 35 Leicester, Leicestershire & Rutland System Resilience Group
- 36 Solihull Together for Better Lives
- 37 South Devon and Torbay System Resilience Group

Acute care collaborations - linking hospitals together to improve their clinical and financial viability

- 38 Salford and Wigan Foundation Chain
- 39 Northumbria Foundation Group
- 40 Royal Free London
- 41 Foundation Healthcare Group (Dartford and Gravesham)
- 42 Moorfields
- 43 National Orthopaedic Alliance
- 44 The Neuro Network (The Walton Centre, Liverpool)
- 45 MERIT (The Mental Health Alliance for Excellence, Resilience, Innovation and Training) (West Midlands)
- 46 Cheshire and Merseyside Women's and Children's Services
- 47 Accountable Cancer Network (ACN)
- 48 EMRAD - East Midlands Radiology Consortium
- 49 Developing One NHS in Dorset
- 50 Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)



The vanguards: integrated primary and acute care systems

1. Wirral Partners

Working together without boundaries to improve health

Healthy Wirral is all about supporting and empowering people to live happy, fulfilling lives, wherever they live in the community, and whatever their situation; and providing the environment for the diverse workforce to deliver outstanding care and support to the population, whatever their role.

The vanguard and the people it serves

Healthy Wirral is a partnership between the organisations that deliver health and social care in the local community, including NHS Wirral Clinical Commissioning Group; Wirral Council; Wirral University Teaching Hospital NHS Foundation Trust; Wirral Community NHS Trust; Cheshire and Wirral Partnership NHS Foundation Trust and the local professional committees (medical, optometry, pharmacy, dentistry). The core partnership also receives important support from Community Action Wirral and other third sector partners, Healthwatch Wirral and the Cerner Corporation.

Together they serve a population of 330,000 people.

Website: www.healthywirral.org.uk

Twitter: [@healthy_wirral](https://twitter.com/healthy_wirral)

Contact: jon.develing@nhs.net

What is changing?

The partners are focused on shaping local services around what really matters to everyone in Wirral.

To do this, the organisations are working much more closely together, commissioning (buying) services jointly, supporting joined-up local services, and working in partnership with the large and diverse local communities and voluntary sector.

The vanguard is using support from the national new care models programme for working with new technologies to develop Europe's first 'population health management digital infrastructure' – a new system where electronic patient records are shared across all health providers.

The information that can be gained from the system – such as the numbers of people with certain health conditions and any trends or patterns in who becomes unwell – can be used to better plan the services that the population needs and improve the efficiency of the health and care system.

Key benefits

- Improving health and wellbeing outcomes
- Improving patients' and service users' experience
- Providing efficient, well organised and value for money health and social care services.

2. Mid Nottinghamshire Better Together

A 'bold vision' for high quality, sustainable services

Better Together's aim is to ensure that people across mid-Nottinghamshire receive the best possible care in the community and in hospital, with high quality, sustainable services.

The vanguard has set out a bold vision for the way health and care services will look over the next five years, based on population needs and public, stakeholder and staff feedback about current services.

The vanguard and the people it serves

The vanguard partners are Nottingham Emergency Medical Services; East Midlands Ambulance Service NHS Trust; Nottinghamshire County Council; Nottinghamshire Healthcare NHS Foundation Trust (including County Health Partnerships); Nottingham University Hospitals NHS Trust; Sherwood Forest Hospitals NHS Foundation Trust; United Lincolnshire Hospitals NHS Trust and Together Everyone Achieves More.

Together they serve a population of around 310,000.

Website: www.bettertogethermidnotts.org.uk

Twitter: @bettermidnotts

Contact: nshccg.bettertogether@nhs.net

What is changing?

The vanguard is receiving support from the national new care models team to support its work to empower patients and communities to better support their own health, and in its work towards greater integration of health and care services.

This means getting doctors, nurses, other health professionals and social care staff to work more closely together to support the needs of patients, their families and carers.

The vanguard is focusing on several important areas:

- Urgent and proactive care (e.g. long term conditions and frail older people); and
- Early and planned care (e.g. surgery for hips, knees or cataracts).

The benefits of working more closely together include better, more co-ordinated care for patients, better working relationships and clearer processes for staff.

An example of the changes being made is the creation of new integrated care teams. The integrated care team includes GPs, specialist nurses (e.g. diabetes, cardiac), social workers and a voluntary sector worker. They work closely with other community teams to provide better, joined-up care for patients who are at high risk of being admitted to hospital.

A new process called 'transfer of care' now allows patients to be discharged from hospital as soon as they are medically fit, with wide-ranging health and social care support already put in place.

Key benefits

- Reduce pressure on hospitals by helping patients leave hospital sooner
- Patients receive more and better care closer to home.

3. South Somerset Symphony Programme

Coming together to look after people's health and wellbeing as a whole

This vanguard is developing a new system for delivering health and social care in south Somerset which allows staff from a range of organisations to work together, providing the population with quicker and easier access to services and support.

This will be delivered through a new organisation that is jointly managed by health and social care professionals.

The vanguard and the people it serves

The vanguard partners are Yeovil District Hospital NHS Foundation Trust; the Somerset GP Federation (a group of GPs); Somerset Clinical Commissioning Group and Somerset County Council. Together they serve a population of 200,000.

Website:

www.symphonyintegratedhealthcare.com

Twitter: @SymphonyProj

Contact: lisa.pyrke@ydh.nhs.uk

What is changing?

The Symphony project is developing new ways of caring for patients that either help to prevent ill health or address any potential problems as early as possible.

Services will be available closer to where people live and patients – particularly those with complex conditions – will be supported to stay independent and healthier for longer and avoid unnecessary hospital admissions.

GPs, hospital clinicians, therapists, social workers and patients will work together to develop packages of care which cover all of an individual's care and lifestyle needs.

Symphony is also exploring new ways of working to make some routine clinical work – such as certain day surgery procedures – easier for patients to access and more efficient.

Key benefits

- By working together in a proactive way, the partners will help prevent ill health and reduce the reliance on health and care services
- Patients will receive care earlier and quicker thanks to a more efficient use of resources.

4. Northumberland Accountable Care Organisation

Consistent care and a seamless patient experience

The collective vision of health and social care partners in Northumberland is to create a system which consistently delivers the highest quality of care and a seamless patient experience for people living across the county.

This vision is supported by plans to develop a single accountable care organisation: this is an overarching organisation that sits above a joined up health and social care system made up of a number of different providers, from health services to the local council. The aim is to help teams across different organisations to work more effectively together, with the same shared goals.

The vanguard and the people it serves

The vanguard partners are Northumbria Healthcare NHS Foundation Trust; NHS Northumberland Clinical Commissioning Group and Northumberland County Council working together with local GPs, mental health services, the ambulance service, local patients, Healthwatch and the Health and Wellbeing Board.

The NHS organisations jointly serve a population of more than 320,000 people across Northumberland – one of the largest and most rural areas of England.

Website: www.northumberland.nhs.uk

Twitter: @N_LandNHS

Contact: andrea.stoker@northumbria.nhs.uk

What is changing?

Urgent and emergency care has already been transformed, with the opening of the Northumbria Specialist Emergency Care Hospital in June 2015. This new hospital, the first purpose-built of its kind in England, provides specialist consultant-led care, seven days a week, for all serious emergencies. Urgent care centres for walk-in patients with less serious problems are now available 24/7 at general hospital sites.

Development is now focused on improving access to GP advice during the normal working week and exploring the potential for new networks of GP practices to work together to offer extended access, based on patient need, across the county.

To support this, new locality based multi-disciplinary teams are piloting new ways of working to proactively look after patients who are most vulnerable, as close to home as possible. This includes an acute home visiting service using pharmacists and the wider community nursing team to support GPs in managing home visit requests as well as working with colleagues from mental health and other specialists to proactively support people with long term health problems to stay healthy and well.

Key benefits

- Improved outcomes for seriously ill patients requiring emergency hospital care
- Increase same day access to GP advice and reduce out-of-hours activity
- Reduce reliance on emergency care and hospital admissions
- Create more time for GPs to plan and care for those with long term or complex needs
- Supports the future efficiency and financial stability of the health and social care system as a whole.

5. Salford Together

Improving health and care for older people

Salford Together aims to improve health and social care for older people through better links between GPs, district nurses, social workers, mental health professionals, care homes, voluntary organisations and local hospitals.

The vanguard and the people it serves

The partners include Salford City Council; NHS Salford Clinical Commissioning Group; Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust.

Salford has a population of 230,000.

Website: www.salfordtogether.com

Twitter: [@SalfordTogether](https://twitter.com/SalfordTogether)

Contact: rob.pett@nhs.net

What is changing?

The vanguard is developing groups of staff, including a range of health and care professionals, who will work together to provide targeted support to the most vulnerable people.

There is also a new focus on preventing ill health through increased screening for health conditions and helping people find support available locally to improve their health and wellbeing.

A new contact centre will act as a central health and social care 'hub', supporting the multidisciplinary groups of staff and co-ordinating the use of telecare (modern technology that helps keep patients safe at home). Staff in the centre will also help local people find and access community support to help them remain independent and develop greater confidence to manage their own care.

Patients will no longer have to tell their story to different professionals many times, as staff involved in their care will share information and ensure that care is designed to meet their individual needs.

Better communication and planning between professionals and services involved in an individual's care will also help staff deliver a high quality of care effectively and efficiently.

Key benefits

- Sharing expertise and resources will allow staff to create more effective and efficient personalised services
- Patients will be kept safely at home for longer and receive care closer to home instead of in hospital.

6. Better Care Together (Morecambe Bay Health Community)

Empowering communities to deliver their own healthy futures

The aim of Better Care Together is to enable the communities around Morecambe Bay to be as healthy as they can be.

This will involve delivering the 'triple aim' – better population health, better quality services, delivered at a lower cost and with higher staff morale.

The vanguard and the people it serves

The Bay Health Partners are University Hospitals of Morecambe Bay NHS Foundation Trust; Cumbria Partnership NHS Foundation Trust; North West Ambulance Service; Blackpool Teaching Hospitals NHS Foundation Trust; Lancashire Care NHS Foundation Trust; Lancashire County Council; Cumbria County Council; NHS Lancashire North Clinical Commissioning Group; NHS Cumbria Clinical Commissioning Group; North Lancashire Medical Services and South Cumbria Primary Care Collaborative.

The vanguard partners serve a population of 365,000 people in an area that is geographically spread out, financially challenged and with significant deprivation and health inequality.

Website: www.bettercaretogether.co.uk

Twitter: @BCTMorecambeBay

Contact: paul.wood@mbht.nhs.uk

What is changing?

Twelve new health and care teams are being created, including professionals (nurses, doctors, social workers) from across primary, secondary and community care. These teams have a mix of different health and care skills. They will be based in local areas and called 'integrated care communities'. These professionals will work together, across the area, in three clinical networks.

The aim is to deliver consistent care for individuals but with priorities localised (for example the priorities for the people of Kendal will be different to those for the people of Barrow-in-Furness). Care will be provided as close to home as it can be with people going to hospital only when they need the specialist care that only a hospital can provide.

Key to success is that whole communities become much more involved in better managing their own health and wellbeing, as improved population health cannot be achieved just through service delivery.

Key benefits

- Improved consistency and quality of care, both in and out of hospital
- People to be cared for as close to home as they can be, with hospitals concentrating on those patients who need specialist treatment or emergency care
- A health system with exciting and innovative teams working together.

7. North East Hampshire and Farnham

Happy, healthy, at home

The vanguard is aiming to keep people happy, healthy and at home by motivating and supporting local people to improve their own health and by ensuring a seamless health and care service when they are ill or need support.

The vanguard and the people it serves

The partners include NHS North East Hampshire and Farnham Clinical Commissioning Group; Frimley Health NHS Foundation Trust; Southern Health NHS Foundation Trust; Surrey and Borders Partnership NHS Foundation Trust; Virgin Care; South East Coast Ambulance NHS Foundation Trust; North Hampshire Urgent Care; and Hampshire and Surrey county councils.

It serves a population of more than 220,000.

Website: www.happyhealthyathome.org

Contact: nehfvanguard@nhs.net

What is changing?

The aim of the Happy, Healthy, at Home vanguard is to keep patients as well as possible and out of hospital where appropriate.

Becoming a vanguard has given the partners a 'turbo boost' to accelerate their plans to reshape the ways health and care providers are set up and paid to work together. This will include new integrated teams of specialist health and social care professionals who will ensure joined up care for patients, especially those who are vulnerable or have complex needs.

The teams will include community nurses, occupational therapists, physiotherapists, social workers, a psychiatric nurse, a lead psychiatrist, a pharmacist, a geriatrician (doctor specialising in care for older people), GPs, the voluntary sector, specialists for people who are terminally ill and their families, and home carers.

Improved services will be available in people's own homes, in GP surgeries and local community hospitals and specialist inpatient care will be available in community hospitals such as in Farnham and Fleet as well as Frimley Park Hospital.

The programme will also focus on preventing ill health, helping people better manage their own health and wellbeing, and ensuring the right services are available to all.

Key benefits

- The better value for money delivered through new ways of working will help close the gap between the available resources and the costs of providing services to meet needs
- Supporting a happy, healthier population to live independently will reduce demand and reliance on health and care services.

8. Harrogate and Rural District Clinical Commissioning Group

Taking a new look at team working

This vanguard aims to transform the way care is provided locally with GPs, community services, hospitals, mental health and social care staff working together to support people to remain independent, safe and well at home.

The vanguard and the people it serves

The vanguard partners include Harrogate and District NHS Foundation Trust; Harrogate and Rural District Clinical Commissioning Group; North Yorkshire County Council; Tees Esk and Wear Valley Foundation Trust; Harrogate Borough Council and Yorkshire Health Network (representing the 17 general practices in the District).

The vanguard covers a population of approximately 160,000.

Website: www.whatmatterstous.org

Twitter: [@WMTU_Harrogate](https://twitter.com/WMTU_Harrogate)

Contact: hardccg.ncm@nhs.net

What is changing?

The 'What matters to us' vanguard's work is built on what local people said is important to them. Services will be provided by an integrated (joined-up) care team including GPs, community nurses, adult social care, occupational therapy, physiotherapy, mental health, geriatricians and the voluntary sector.

Where possible, care will be provided by the same people each time, so that patients and their families can get to know and trust their team. Their care plan will set out their goals and the support they will receive to achieve them, pre-empting need and planning better in advance.

Boundaries between primary, community, acute, mental health and social care are being removed and hospital beds will be used only when they are truly needed. A response and overnight service will provide rapid support and social care staff will work with A&E, both helping to avoid admissions to hospital. Community beds are available for those who need a little more support.

The vanguard also focuses on early intervention, prevention and promoting self-care. Services supporting health and wellbeing will be better coordinated and include voluntary and community sector services, local council services, the police and fire and rescue services. Prevention will focus on falls, mental health and strokes.

Key benefits

- A focus on prevention and self-care will help support independence and reduce the need for interventions from health or social care services
- High quality and sustainable services will offer value for money and be clinically and financially sustainable
- Local and personal support will help reduce unnecessary hospital admissions.

9. My Life a Full Life (Isle of Wight)

Working together to support an island community

The Isle of Wight vanguard is enhancing the care it offers by delivering more services in people's own homes and in the community, and by working in ways that are sustainable over the long term as they offer better value for money for the NHS.

The vanguard and the people it serves

The partners include Isle of Wight Clinical Commissioning Group; Isle of Wight NHS Trust (a unique provider of ambulance, community, hospital, learning disability and mental health services); Isle of Wight Council; One Wight Health (a group of GPs); the voluntary and independent sectors and other public sector organisations.

The partners jointly serve a population of 140,000 residents as well as thousands of tourists.

Website: www.mylifeafulllife.com

Twitter: [@MyLifeAFullLife](https://twitter.com/MyLifeAFullLife)

Contact: mlafl@iow.gov.uk

What is changing?

'My Life a Full Life' aims to prevent ill health by promoting health and wellbeing and supporting self-care and empowered communities. Health and care services for individuals is coordinated by dedicated staff including community and care navigators and local area coordinators, who help patients access the right service, reduce any confusion by simplifying how the system works and increase awareness of the services available.

New locality teams are also being introduced to deliver care and support in the community, with GP clinical leadership and teams of staff with a mix of skills and specialisms.

Services will work together to jointly assess people's needs and provide the right service, in the right place at the right time, avoiding unnecessary hospital admissions and reducing inappropriate referrals to services.

At the same time, the partners are breaking down barriers and working more efficiently together, making the most of their combined resources.

Key benefits

- Easy to understand, accessible and up to date information about health, wellbeing, care and support helps local people take better care of themselves
- Access to skilled advice helps people plan better for their future and take more direct control over their care
- Services delivered closer to home support people to remain happy and healthy in their own communities, only going to hospital when they really need to.

The vanguards: multispecialty community providers

10. Calderdale Health and Social Care Economy

Shaping healthier living

The vanguard in Calderdale will deliver care that is personalised, co-ordinated, and helps individuals better manage their own health and wellbeing. The new model of care will be created in partnership with carers, citizens and communities and its delivery will be supported through increased volunteering and social action.

The vanguard and the people it serves

The vanguard is made up of seven equal partners including Pennine GP Alliance - a federation of all 26 practices in Calderdale; Calderdale and Huddersfield Foundation Trust; Calderdale Clinical Commissioning Group; Calderdale Metropolitan Borough Council; South West Yorkshire Partnership Foundation Trust; Locala; and Voluntary Action Calderdale, representing over 100 third sector organisations working in health care related sectors.

Calderdale currently has a population of over 210,000 people, which is set to increase, with the largest increases being in people aged over 65 and children. With a diverse mix of rural and urban areas, different communities and ethnic groups, there are variations in the health and social care needs of people across the district.

Contact: amanda.jenkinson@nhs.net or rosemary.cowgill@nhs.net

What is changing?

Through working with partners in the vanguard and with the support of their community panel members', fundamental change will take place to improve outcomes and the experiences people have of services and the quality of care received.

Underpinned by and based on a strong ethos of collaborative working with professionals in practice and the public, developed over a number of years, the vanguard aims to achieve a person-centred, personalised, empowering and co-ordinated model of care delivered in communities, at the right time, in the right place.

At the heart of a wider system of care will be general practice, supported by multi-disciplinary teams of professionals working within a newly devised localities model developed to create flexible, responsive, local services which ensures equal access to services for people across Calderdale.

The vanguard will develop seamless service provision across the social care and health system which is tailor made for communities and based on robust insight gained from many years of working with the people of Calderdale to understand their views of services, needs, wants and aspirations for the future.

Key benefits

- Improved access through a reshaped first point of contact where care co-ordinators are supported by community based volunteers and professionals in a range of disciplines
- Provision of enhanced levels of care for people with complex needs
- More care delivered in community and primary care settings to reduce unnecessary hospital admissions
- Placing people at the centre of their own care, enabling them to access the right care, at the right time, in the right place.

11. Wellbeing Erewash

Delivering thriving, capable and healthier communities

The vanguard wants to develop thriving communities within Erewash where people feel confident and supported to choose a healthier lifestyle, stay well, and know how to get help and support when they need it.

The vanguard and the people it serves

The partners include Derbyshire Community Health Services NHS Foundation Trust; Derbyshire Healthcare NHS Foundation Trust; Erewash Health GP Federation; Derbyshire Health United; and NHS Erewash Clinical Commissioning Group.

Together they cover a population of 97,000 people.

Website: www.wellbeingerewash.org.uk

Contact: carol.foster@erewashccg.nhs.uk

What is changing?

The Wellbeing Erewash partners will work together to create a 'multispecialty community provider', in which primary (GP) and community services will connect with local councils, the voluntary and community sector and local communities to meet the needs of the local population efficiently and effectively.

The aim is to remove the 'boundaries' that exist between organisations – making it much easier for joined up, person centred working, shaping new services that give local people the information and confidence they need to support themselves and reduce their reliance on health and social care services.

The vanguard will work with communities to promote self-care through education and a greater availability of health information, linking people into their communities for support, by training and supporting staff to talk to patients and involve them in making decisions about their own health and care. Vulnerable patients who are at risk of ill health and hospital admissions will also be identified and offered specific support by the community teams.

New services (including urgent care services) are being designed which will be available on the day they are requested, seven days a week. Access to primary care will be improved by matching GP availability to patient needs and by delivering services in different ways.

Key benefits

- Greater support for self-care and healthy lifestyle choices will help reduce reliance on health and care services
- Staff will feel empowered to deliver better services through improved working relationships and processes taking a patient centred approach.

12. Fylde Coast Local Health Economy

'Wrapping' healthcare around the patient

The vision for the Fylde Coast is to develop healthcare that 'wraps around' the patient, delivering more support closer to people's home and less in hospital.

The vanguard and the people it serves

Vanguard partners include NHS Blackpool and NHS Fylde and Wyre clinical commissioning groups; Blackpool Teaching Hospitals and Lancashire Care NHS Foundation Trusts, plus Lancashire County Council and Blackpool Council.

Together, the clinical commissioning groups have a registered population of 320,000 living across a mix of coastal towns and rural villages.

Website: www.yourcareourpriority.nhs.uk

Twitter: @YCOPFyldeCoast

Contact:

fyldecoast.vanguard@blackpool.nhs.uk

What is changing?

The new care models programme is supporting the vanguard partners to work better together and design new care models to support the overall health and wellbeing of local people.

A new community based service called 'extensive care' is providing proactive support for people aged 60 and over, who have two or more long-term conditions. Under the service, patients benefit from a harmonised team of health and care professionals working together to provide the support they require to keep them out-of-hospital. This includes helping people to understand and manage their health conditions but also other aspects of their life which might impact upon their general wellbeing.

Complementing the extensive care service are locally based neighbourhood care teams which provide support to people who require the ongoing management of one or more long-term condition.

These teams see GPs working with community and other care services across ten neighbourhoods on the Fylde Coast to provide better coordinated care closer to home for patients.

Shared electronic care records and a single point of contact for all out-of-hospital services on the Fylde Coast ensure seamless care regardless of a person's support needs.

Key benefits

- Helps patients feel more empowered with support to better manage their conditions and stay healthy
- Relieves pressure on the health system through better coordination and fewer unnecessary hospital admissions
- Better patient experience as a result of coordinated, streamlined care through a single point of access and agreed shared electronic care records.

13. Modality Birmingham and Sandwell

Modality offers a new model of care to improve health services

The vanguard partners are developing a new way of working together that will help improve the overall health and wellbeing of people in Birmingham and Sandwell. This will include high quality, coordinated care in the right place at the right time, with information available to also help people support their own health.

The vanguard and the people it serves

The partners include Birmingham City Council; Birmingham Community Health Care NHS Foundation Trust; Birmingham and Solihull Mental Health Foundation Trust; Sandwell and West Birmingham Clinical Commissioning Group; Modality Partnership (a network of 24 GP practices) and Intelligent Commissioning Federation GP Federation (a network of 15 GP practices).

The vanguard covers 160,000 patients within Birmingham and Sandwell.

Website: www.modalitypartnership.nhs.uk

Twitter: @ModalityMCP

Contact: juliehales@nhs.net

What is changing?

The vanguard is creating a new system where health and care partners work together, led by Modality, a GP super partnership. The new ways of working that are being introduced will include a 24/7 single point of entry, offering more alternatives to hospital care and specialised care closer to home, and helping local people manage their own health confidently.

A range of services will be available to help people stay well and healthy or to regain their health after illness in the place they prefer with the type of support they want. This will include home and community-based services to help keep people out of hospital and reduce pressure on GPs.

Help and information will also be available for people with long-term health conditions to help them understand them and to stay as healthy as possible, knowing any potential complications and risks and how to best manage their own health safely.

Key benefits

- Supporting people to manage their own health will reduce unnecessary hospital admissions and pressure on GPs
- Working together better will support a more sustainable, cost-effective health and care system.

14. West Wakefield Health and Wellbeing Ltd

Helping local people access the care they need

One of the vanguard's key aims is improving the way local people access services and support through a better 'care navigation system'. The improved system will help direct people more efficiently to the right care at the right time and make it easier and quicker for patients to get the help they need.

As part of this work West Wakefield Health and Wellbeing Ltd, a formal network of GP practices in West Yorkshire, is working to provide a larger, more diverse primary care team that delivers services 'on the ground'.

The vanguard and the people it serves

In addition to West Wakefield Health and Wellbeing Ltd, the vanguard partners include: NHS Wakefield Clinical Commissioning Group; Wakefield Council; Wakefield District Housing; South West Yorkshire Partnership NHS Foundation Trust; Healthwatch Wakefield; Mid Yorkshire Hospitals NHS Foundation Trust; NOVA (voluntary community sector representative organisation); Yorkshire Ambulance Service and Local Care Direct.

West Wakefield covers around 65,000 patients and the vanguard is also working with two other GP practice networks in the area, covering a patient population of 152,000.

Website: www.westwakefieldhealthandwellbeing.nhs.uk

Twitter: @westwakefield

Contact: kara.dudley@westwakefield.org.uk

What is changing?

Local people are being helped to access the care they need by more than 100 'care navigators' based in GP practices. These are mostly the support and administrative staff who have the first contact with patients when they come into or call the surgery, and they are trained to direct patients to the most appropriate care.

Other work underway includes:

- Extended operating hours for GP services with plans to roll this out to the other GP networks linked to the vanguard;
- The development of integrated community teams with members from physical health, mental health and social care services, who care for the most vulnerable people;
- The HealthPod mobile clinic, which is improving engagement with 'hard to reach' groups such as the gypsy/traveller community; and
- Improved technology for sharing patient information as needed to prevent hospital admission and support earlier discharge.

The vanguard is also creating more ways for people to access healthcare digitally, through an online directory of local services and a library of helpful health apps including one designed by primary school pupils. Self-service kiosks in practices will help patients access these and other digital resources.

Key benefits

- Patients are helped to access the right care at the right time
- Increasing the number of ways to access services will support better self-management of health and wellbeing
- Sharing information will help reduce hospital admissions and speed up discharge.

15. All Together Better Sunderland

A focus on keeping patients safe and well at home

The vanguard in Sunderland has an ambitious vision to transform care by improving the links between its hospitals and community services with teams working together to provide individually tailored and better coordinated care for patients at home.

The vanguard and the people it serves

The partners include NHS Sunderland Clinical Commissioning Group; Sunderland City Council; Sunderland Care and Support (reablement and community-based support services); South Tyneside NHS Foundation Trust (community services in Sunderland); and City Hospitals Sunderland NHS Foundation Trust. It also includes the city's two GP Federations (Sunderland GP Alliance and Washington Community Healthcare); Sunderland Carers Centre; Age UK Sunderland; and Northumberland and Tyne and Wear NHS Foundation Trust.

The vanguard covers a population of 275,500 people.

Website: www.atbsunderland.org.uk

Twitter: @ATBSunderland

Contact: kerry.mcquade@ntw.nhs.uk

What is changing?

The vanguard is delivering a citywide 'recovery at home' service offering a rapid response either at home or in places close to home (in the community) to prevent emergency admissions to hospital and also to provide short-term support to patients after they are discharged from hospital.

Community nurses, social workers, GPs and voluntary staff are linked together in five locality teams based around clusters of GP practices. These 'community integrated teams' are supported by the recovery at home service and offer better co-ordinated care and work to prevent ill health, particularly for patients most at risk of avoidable emergency admission to hospital.

GP practices are also working together to deliver an enhanced primary care programme for patients with a long term condition who could benefit from 'self-care' opportunities. Representatives from many of the city's GP practices – who are often closest to people living with long term health conditions – are working to redesign care for them looking at how they can deliver the best possible level of care, while also ensuring it is delivered in the most efficient way possible.

Key benefits

- High quality community and home-based care will benefit those people who need it most and who use the most health and social care services in the city
- Family or friends looking after vulnerable people will get more support to maintain that level of unpaid care
- Staff will be able to influence how well a service is delivered and gain a better understanding of their colleagues' roles, improving overall care provision
- Reduction in non-elective activity, continued reduction in delayed transfers of care, and improved patient and staff satisfaction.

16. Dudley Multispecialty Community Provider

Creating better links to improve care

The aim in Dudley is to improve health and wellbeing for local people through more closely linked health and care services, based around GP practices, which allow easier access to care that is consistent and better co-ordinated.

The vanguard and the people it serves

All Together Better is a partnership between local NHS and care organisations, GPs and the voluntary sector. The partners are working together with support from the national programme team to develop an overarching organisation known as a multispecialty community provider to improve the quality of care for all people in Dudley registered with a GP.

The area has a population of 315,000.

Website: www.dudleyccg.nhs.uk/alltogetherbetter

Twitter: @ATBDudley

Contact: laura.broster@dudleyccg.nhs.uk

What is changing?

The team in Dudley is developing a network of GP-led teams of staff working together across health and care professions for the benefit of patients – known as ‘teams without walls’.

The focus is on four main areas:

- Enhanced primary care – including consistent and more co-ordinated support for people with long term conditions that is tailored to their needs;
- Integrated care – patients can be supported by a wide ranging team made up of a GP, community nurse, social worker, mental health worker, voluntary sector worker and other specialists;
- Pathways – people will be supported to remain at home wherever possible by reducing the variation in hospital care for patients referred by their GP for non-emergency care; and
- Urgent care – the vanguard will build on Dudley’s successful new urgent care centre by improving support for frail elderly people, reducing the number of times they need to go to hospital as an emergency.

Key benefits

- More straightforward access to a wider range of care via local GP practices will improve health and wellbeing and reduce unnecessary hospital admissions
- More advice and guidance and better access to local support groups will help people make the right choices and manage their own health
- Efficiency will be improved through staff working together as one team, regardless of which organisation employs them.

17. Encompass (Whitstable, Faversham and Canterbury)

An inclusive way of working to offer the best care

The new model of care being developed by Encompass, a multispecialty community provider vanguard, will ensure health and social care works together. The model provides patient care designed to meet local people's needs and ensure patients receive more services close to their homes, rather than having to travel to hospital.

The vanguard and the people it serves

The 16 GP practices that make up Encompass are working in partnership with all sections of the health and care system to develop and deliver new models of care, as set out in the NHS Five Year Forward View and supported by the national expertise offered through the new care models programme.

The vanguard participants also include NHS Canterbury and Coastal Clinical Commissioning Group; Kent County Council; Pilgrims Hospices; local NHS trusts; mental health services; public health; and voluntary and community services. The organisations jointly serve a population of approximately 170,000 people across Whitstable, Faversham, Canterbury, Ash and Sandwich.

Website: www.encompass-mcp.co.uk

Contact: info@encompass-mcp.co.uk

What is changing?

Primary and community care services will be expanded with the aim of reducing the number of admissions to hospital and the length of a patient's stay in hospital.

The Encompass vanguard will create a more cost-efficient and clinically effective service by treating patients closer to home using specialist GPs, health professionals such as occupational and physical therapists, and community-based consultants, who will coordinate and simplify services.

There will also be greater use of information technology. Telecare and telemedicine systems – which use a network of remote sensors and systems to monitor patients – will enable people to maintain their independence through self-care and self-management. The use of shared single electronic patient records will support integrated care as any number of health care professionals involved in an individual's care can access their complete and up-to-date information.

Four health and social care 'hubs' will also be created. These will provide a central point for health and social care covering some nursing home and hospital in-patient services.

Additionally, a focus on preventing ill-health will ensure that the whole health and social care system works seamlessly to support people to stay well when they can, and work together to provide quality treatment where necessary.

A federation of GPs will work in partnership with everyone involved in health and social care across the local area, including the voluntary sector and patient groups.

Key benefits

- Reduced number of hospital admissions by providing more care in the community
- Improved health of local people by helping them stay healthy.

18. Stockport Together

Stockport services come together to improve care

Stockport Together is developing plans for its local hospital, GPs, community, social and mental health services to come together to form one new organisation to provide improved health and social care for local people.

The vanguard and the people it serves

The organisations linking up to form 'Stockport Together' include Stockport NHS Foundation Trust (for hospital and community services); NHS Stockport Clinical Commissioning Group; Pennine Care NHS Foundation Trust (for mental health services); Stockport Metropolitan Borough Council along with Viaduct Health (the GP federation which represents Stockport's 45 practices); and third sector voluntary organisations.

Stockport Together will serve a GP registered population of more than 305,000.

Website: www.stockport-together.co.uk

Twitter: @Stockport2gthtr

Contact: lucy.cunliffe@nhs.net

What is changing?

The 'Stockport Together' partners will work alongside other local services such as pharmacists, opticians and others in the community to revolutionise the way people receive health and care. More care will be provided in local neighbourhoods, led by GPs and delivered closer to people's homes.

By focusing on delivering support in the community, more services will be offered out-of-hospital to help patients' access self-care support to help them improve their own health and wellbeing, with the aim of preventing ill health.

Initially, Stockport Together will deliver care to people aged over 65 to provide support through education about their health conditions, enabling them to better manage their own care.

Where people with complex conditions have a sudden problem with their health, a crisis response will be offered by the health and social care team in their neighbourhood to help them stay safely at home and avoid a trip to hospital.

Patient records will be shared electronically so that GPs, community nurses and social workers can see and share the information needed when they are caring for individual patients.

The funding received as part of the new care models programme is allowing the vanguard to continue running its existing services at the same time as looking at and testing new initiatives to improve the efficiency of services and offer a better patient experience of care.

Key benefits

- Improved quality of life for people with complex and long term health conditions
- More care closer to people's homes
- Improved and more proactive care in nursing homes and those with dementia.

19. Tower Hamlets Together

Working together to tackle the toughest health inequalities

Tower Hamlets faces some of the toughest health inequalities in the UK caused by high levels of deprivation. Almost 40 per cent of the borough's children live in poverty and the area has the second highest premature death rate amongst adults from circulatory disease, cancer and respiratory disease of all the London boroughs.

Coupled with this, the local population is growing fast, which will lead to even greater health inequalities if the vanguard fails to act now. That is the driver for the new models of care and why partnership sits at the heart of how Tower Hamlets Together works – recognising that no one organisation can do all that needs to be done in isolation.

The vanguard and the people it serves

The partnership includes commissioners and providers of acute, community, mental health, social care and primary health services, including: Barts Health NHS Trust; East London Foundation Trust; Tower Hamlets Council; Tower Hamlets GP Care Group; and NHS Tower Hamlets Clinical Commissioning Group.

The vanguard is also developing close working links with wider partners including the local community, voluntary sector and hospice.

Tower Hamlets Together serves a population of approximately 287,000 people.

Website: www.towerhamletstogether.com

Twitter: @TH2GETHER

Contact: thccg.towerhamletstogether@nhs.net

What is changing?

Tower Hamlets Together is a multispecialty community provider vanguard, which means partners will work together to deliver innovative, integrated and seamless care to patients, carers and families. Care will be user focused and better coordinated to reduce duplication and improve patient experience.

The vanguard plans to achieve this through the delivery of an ambitious programme of transformation which includes a model of care for adults with complex needs, a model of care for children and young people and the development of a population-wide health programme that focuses on prevention.

These new models of care will encourage the residents of Tower Hamlets to find and develop resources and skills within themselves and their communities and to have the confidence to work in partnership with services to improve their own and their families' health and wellbeing.

More patients will have their care coordinated around their needs rather than having to navigate numerous different services and more vulnerable patients will receive care in their own homes, reducing the time they have to spend in hospital away from their family and friends.

Key benefits

- Working together to offer joined-up, patient focused care
- Helping people look after themselves better, reducing pressure on the health and care system.

20. Better Local Care (Hampshire)

Focusing on communities to support self-management

Better Local Care multispecialty community provider vanguard, will support people in taking a more active role in managing their own care and will offer access to improved care where needed.

The vanguard and the people it serves

The Better Local Care vanguard is a partnership of GPs, NHS providers and commissioners, Hampshire County Council, local councils of voluntary services, a number of local community, voluntary and charity organisations, patients and the public.

It covers a population of over one million, focusing on 14 natural communities including rural areas (South West New Forest) and semi-rural areas (East Hampshire) with difficult transport links, an ageing demographic and an urban population with high levels of deprivation, which places significant pressure on local GPs (Gosport).

Website: www.betterlocalcare.org.uk

Twitter: @BetterLocalCare

Contact: enquiries@betterlocalcare.org.uk

What is changing?

The vanguard will improve and simplify access to a wider range of care through GP practices and primary care hubs. These services will provide more joined-up care and will be developed in partnership with the people who use them.

As a vanguard, the teams can also access national support in empowering patients and communities, and there will be an increased focus on education and prevention of ill health. With more advice and guidance on offer, local people will be supported to make the right choices to successfully manage their own health and care.

Increased support in the community will help older, vulnerable patients and those with long term conditions remain safely at home. GPs will work with patients to develop care plans to help them maintain their independence and manage any existing health conditions, such as diabetes.

Work is also underway to develop new ways of delivering urgent care through a same day access pilot. A new integrated care record will mean patients no longer have to repeat their medical history to different professionals and staff will be instantly up to speed with their needs wherever they go for help.

Key benefits

- More services tailored to individuals helping people stay healthy and safe at home
- Supporting the urgent care system to keep people out of hospital
- More sustainable services.

21. West Cheshire Way

Giving people the tools to live happy and healthy lives

With an emphasis on transforming care from cradle to grave, the West Cheshire Way vanguard is focusing on 'Starting Well, Being Well and Ageing Well' as the drivers for change.

Local people will be encouraged to take more control of their own health and wellbeing and children and young people will be equipped with the tools they need to live happy and healthy lives.

The vanguard and the people it serves

The partners include Primary Care Cheshire (a federation of all 35 West Cheshire practices) and the local community services provider supported by West Cheshire Clinical Commissioning Group; Cheshire and Wirral NHS Partnership Foundation Trust; the Countess of Chester NHS Foundation Trust; Cheshire West and Chester Local Authority; partners from the third sector; and local patient, voluntary and community groups including Healthwatch Cheshire West.

The partners serve a population of around 260,000.

Contact: laura.marsh2@nhs.net

What is changing?

This vanguard is showing how the national programme's support for organisations to empower patients and to better integrate the buying and delivery of services can make a difference to patients while also easing pressure on NHS services.

There will be easier access to more joined-up services in the community through new health and social care teams, wellbeing coordinators and direct access to physiotherapy for patients.

By working together with clinicians to design self-care plans, where appropriate, individuals, their families and carers will be given the tools and confidence to understand and manage their health condition themselves as far as possible.

GPs and community teams will act as the first port of call for accessing coordinated support for children and young people. Adults with long-term conditions will be identified and supported to minimise the impact of their conditions on their daily lives, again with care models designed together with clinicians. Vulnerable older people who are most at risk of poor health and wellbeing will be identified by GPs.

They will then work with that person's nominated care coordinator (who works with health and social care teams to help people obtain care, understand their options and make care decisions) to develop care plans and ensure care is provided by teams with members from the specialties needed.

Key benefits

- Patients work with clinicians to manage their own health better
- Wellbeing coordinators help people manage the wider issues that may affect their health, such as loneliness or financial worries
- Clinicians from various teams work together to deliver more co-ordinated, effective and efficient care.

22. Lakeside Healthcare (Northamptonshire)

Simply better care delivered through enhanced general practice

Lakeside Healthcare, the largest GP-led single 'super-practice' in the NHS, wants to take responsibility for the health of its local population in a way that has not been done before. It aims to develop closer working relationships with both hospital and community services to deliver a better patient experience; a better working environment for staff; and better value for money.

The vanguard and the people it serves

Lakeside Healthcare has a registered patient list of more than 100,000 people, with several branch surgeries and community clinics, overseen by 60 general partners. It plans to increase its patient list to 300,000 people by 2017 and currently operates in Northamptonshire, North Cambridgeshire, South Lincolnshire, Rutland and East Leicestershire.

The vanguard partners include Kettering General Hospital; Northampton General Hospital; Peterborough and Stamford Hospital; Northamptonshire Healthcare Foundation Trust; Corby, Nene and South Lincolnshire clinical commissioning groups; Corby Borough Council; Northamptonshire County Council and various third sector partners and other GP partnerships/federations across Northamptonshire, North Cambridgeshire and South Lincolnshire.

Contact: samclarke@nhs.net

What is changing?

Lakeside Healthcare believes that primary (GP-led) care should be at the heart of plans to deliver low cost, high-quality medical services, because evidence shows that healthcare systems with a greater focus on primary care are more likely to keep people healthier for longer, offer better patient satisfaction and reduce hospital admissions and visits to Accident and Emergency (A&E) departments.

The Lakeside Healthcare model is simple: primary care should be delivered by larger providers that can offer a range of extended services, such as diagnostics (tests), urgent care, minor surgery and out-patient appointments, seven days a week.

Care is delivered by staff with skills and experience across a wider and more diverse range of areas, with less emphasis on the GP, and more use of modern technology, particularly in the way that patients and clinicians talk to each other (for example, offering consultations over Skype). Patients will also be supported to manage their own health better, improving their health and wellbeing and delivering savings for the NHS.

Lakeside Healthcare is using its vanguard programme to deliver a number of new patient-focused service improvements:

- Lakeside extensivist services – for the most vulnerable patients, including the frail and elderly and those with multiple long-term conditions (diabetes, heart problems etc);
- Lakeside enhanced primary care – for complex patients with a single long-term condition;
- Lakeside ambulatory surgical centres – offering greater access to minor and same day surgery in community settings;
- Linking with Lakeside Plus to deliver a nationally acknowledged urgent care service, for example: running the 'front door' at the country's busiest A&E department, Leicester Royal Infirmary and also an award winning service out of our purpose built specialist centres, such as the Corby Urgent Care Centre.

Key benefits

- Better access to specialised and routine care closer to home will reduce unnecessary hospital admissions
- Joined up services will improve support for patients and offer better value for money for the NHS
- More career options will help the vanguard attract and keep the best staff and enable the service to be offered to more patients.

23. Principia Partners in Health (Southern Nottinghamshire)

GP practices lead the way in developing closer working

The twelve GP practices across Rushcliffe are working together to provide a better quality of care through an innovative, more coordinated system that can respond to the needs of individual patients. The aims are to improve people's health, increase staff satisfaction and deliver care in a more cost-effective way.

The vanguard and the people it serves

The new organisation formed by the GP practices, called 'PartnersHealth', is the cornerstone of a new, overarching multispecialty community provider which will bring together general practice, community and local mental health services, social care, third sector, pharmacy, and hospital services.

Together they will serve a population of 124,459.

Website: www.rushcliffeccg.nhs.uk/principia-mcp-vanguard

Twitter: @PrincipiaMCP

Contact: principia.mcp@rushcliffeccg.nhs.uk

What is changing?

The organisations making up the vanguard will promote health and wellbeing through prevention of ill health and by providing care at the right time in the right place.

This will enable people to live independently at home for as long as possible and avoid unnecessary hospital admissions by moving traditional hospital-based services into community settings. This will include specialist long-term care and support for people with health conditions such as diabetes.

By working more closely together, organisations will see better communication between professionals and less duplication of services, making their work more efficient and cost effective as well as offering a better patient experience.

Local people will be empowered to personalise the care they receive, replacing the one-size-fits-all model currently delivered by individual organisations.

The support of the national team is helping the vanguard progress its work to create a multispecialty community provider, offering guidance in areas such as empowering patients and designing new ways of working.

Key benefits

- A far more cost efficient and clinically effective model of care
- Care provided in the right place, at the right time
- A reduction in ill health supported by a focus on prevention and early diagnosis.

The vanguards: enhanced health in care homes

24. Connecting Care - Wakefield District

Improving care for residents in supported housing

Wakefield's vanguard is aimed at improving the health and experience of people living in care homes and supported housing by bringing together primary (GP) care, a mixed team of health and social care professionals, and specialist voluntary workers along with care home managers.

The vanguard and the people it serves

The vanguard partners include NHS Wakefield Clinical Commissioning Group; Wakefield Council; GP practices; and members of Wakefield's Provider Alliance, which includes Nova-Wakefield, Age UK Wakefield District, Wakefield & District Housing, South West Yorkshire Partnership NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust and Yorkshire Ambulance Service.

There are more than 361,000 people registered with GP practices in Wakefield.

Website: www.connectingcarewakefield.org

Twitter: @NHSVanguardWake

Contact: info@connectingcare.org.uk

What is changing?

Dedicated teams of health and care professionals are being allocated to support care homes and supported living schemes in looking after the health and wellbeing of their residents.

Each of the 15 care homes and two supported living facilities in Wakefield that are taking part in the vanguard are being linked to a dedicated GP practice which works with mixed teams including community nurses, therapists, voluntary carers and other professionals to provide a flexible, efficient and responsive service that reacts to the needs of residents.

The team aims to avoid ill health among residents by taking action before people become unwell reducing the need for reactive care and unplanned hospital admissions. They do this by proactively monitoring residents to make sure care for potential health problems is offered as early as possible and by building the skills and confidence of care home staff through training and education.

GPs, health workers and specialist voluntary workers are all be involved in making sure residents in care homes and supported living schemes have their health and social care needs met and are helped to make use of activities in their local community. The organisations believe that as a vanguard they will be able to make further and faster progress than otherwise, and achieve a sustainable system for the future.

Key benefits

- An improved general life experience for residents in care homes and tenants in supported living facilities, as well as better health
- A reduction in the need for urgent health care and hospital admissions for people in care homes
- More efficient and effective partnership working.

25. Gateshead Care Home Project

Going further and faster to improve the health of care home residents

This care home programme will support the health and wellbeing of older people by speeding up improvements in care for residents in Newcastle and Gateshead.

The vanguard and the people it serves

Newcastle Gateshead Clinical Commissioning Group is working with a range of partners including care homes; local authorities (both Newcastle and Gateshead); NHS foundation trusts; independent sector care providers; and the voluntary and community sector.

More than 2,500 people live in residential and nursing care homes in the area.

Contact: ngccg.vanguardcarehome@nhs.net

What is changing?

The programme is building on the extensive range of services to work together to support people in care homes, to improve patients' experience and reduce unnecessary hospital admissions.

The new ways of delivering care will allow for more joined-up care designed to meet individual needs, and this in turn will help prevent ill health and avoidable hospital admissions. Patients will also be offered more control and independence, enabling them to make informed choices about their care, including their preferred place of care.

GP practices will become a link to a specific care home, making it possible to offer greater continuity of care and more effective prevention of illness through regular care home visits.

The new care model will also consider the contracting and payments associated with supporting the new ways of delivering care and will support the development of a 'provider alliance network', linking all parts of the system together.

Key benefits

- There has already been a 14 per cent reduction in avoidable hospital admissions
- By working together, services will deliver more co-ordinated health and social care
- A focus on preventing ill health will improve care home residents' wellbeing and reduce the reliance on health services.

26. East and North Hertfordshire Clinical Commissioning Group

Focusing on workforce development to improve care

The better care for care home residents vanguard is supporting health and social care providers to work together to provide enhanced levels of care for vulnerable patients in care homes and avoid unnecessary trips to hospital.

Many of these frail, elderly patients live with more than one long-term health condition and can quickly become very unwell.

The vanguard and the people it serves

The vanguard partners are East and North Hertfordshire Clinical Commissioning Group; Hertfordshire County Council; and the Hertfordshire Care Home Providers Association, working with a range of other providers.

The CCG covers a population of 580,000, around 17 per cent of whom are aged over 65.

Website: www.enhertsvanguard.uk
Contact: nuala.milbourn@enhertsccg.nhs.uk

What is changing?

The vanguard's main focus is on improving services through workforce development, with new integrated teams and enhanced training. The aim is for staff to feel more valued and confident in their roles and empowered to offer better care for residents.

The new teams being created include GPs, district and practice nurses, mental health nurses, older people's specialists and pharmacists who work closely with care home staff.

Thanks to the funding it receives through the national programme, the vanguard is also able to offer an extra 'complex care premium' which allows care home staff to undertake a new package of training and education, equipping them with enhanced skills to look after patients who have complex needs with increased confidence.

For enhanced urgent care the vanguard aims to bring together additional 'rapid response' teams of community nurses, matrons, therapists and home carers who can arrive at care homes to provide support within 60 minutes. Where appropriate, the teams will be able to put care in place within the home as an alternative to sending elderly patients to A&E.

There will also be an investment in technology to give all GPs access to comprehensive information about each care home resident during visits.

Key benefits

- Improving staff skills and confidence to support care home residents
- Reducing unnecessary and distressing visits to A&E through an improved urgent care service within care homes.

27. Nottingham City Clinical Commissioning Group

Supporting a better quality of life in care homes

This vanguard's vision is to enable residents living in a care home to be healthier, have a better quality of life and to be treated with dignity and respect, focusing on their capabilities rather than their dependencies.

The vanguard and the people it serves

Organisations and networks involved in the Nottingham City Clinical Commissioning Group led programme include Nottingham City Council; Nottingham CityCare Partnership; Nottingham University Hospitals; Nottinghamshire Healthcare; Age UK; and the University of Nottingham.

The population supported by this vanguard is approximately 1,500 Nottingham City GP registered residents living in 53 non-specialist residential and nursing care homes. The average resident has six diagnoses and takes eight medications.

Currently, care homes residents are 0.5 per cent of the city's population but account for five per cent of all hospital admissions. 100 people were admitted to hospital from a care home every month last year, and 26 per cent of residents have a life expectancy of one year or less.

Contact: petra.davis@nottinghamcity.nhs.uk

What is changing?

The vanguard programme is set to improve the way that health and social care services are delivered in care homes. The vanguard has a particular focus on applying the use of technology in care homes and in working with pharmacy experts on medicines management.

There will be greater use of healthcare assistive technology such as blood pressure monitors and modern communications such as video consultations. Residents will also be encouraged to take part in activities that maintain or improve their health and wellbeing.

Key benefits

- Older people receive the best possible care, in the right place, at the right time and retain their independence for as long as possible
- Appropriate care and support in care homes prevents residents being unnecessarily admitted to hospital and enables quicker discharge
- Patients approaching end of life receive high-quality care that supports them to live as well as possible until they die, and to die with dignity.

28. Sutton Homes of Care

A focus on integration, education and quality

The Sutton Homes of Care vanguard sees partners from across health and care working together with care homes and local communities to provide high quality, value for money services that enhance the health and wellbeing of care home residents.

The vanguard and the people it serves

The partners are drawn from a range of NHS and voluntary sector organisations including Sutton care homes; NHS Sutton Clinical Commissioning Group; the London Borough of Sutton; Epsom and St Helier Hospitals NHS Trust; St Raphael's Hospice; Sutton and Merton Community Services (the community division of The Royal Marsden); Age UK Sutton; South West London and St George's Mental Health Trust; The Alzheimer's Society; London Ambulance Service; and Sutton Centre for the Voluntary Sector.

Together, the partners serve a population of 190,000.

Website: www.suttonccg.nhs.uk/vanguard

Twitter: @SuttonHoC

Contact: sutccg.carehomevanguard@nhs.net

What is changing?

The vanguard is focused on developing three key components:

- Integrated care
- Education and training
- Quality assurance and safety.

A number of interventions or actions to prevent unnecessary hospital admissions are already improving the quality of care provided and the aim now is to reach a greater number and range of care home residents, further developing and enhancing the programme.

Joined up teams of medical, nursing, social care and voluntary sector professionals will work together to improve care for each individual, which will result in improved outcomes, particularly for residents with complex long-term conditions or mental illness, including dementia.

Whilst much has already been achieved, the vanguard believes that further work could bring even greater benefits not only in Sutton but also for care home residents nationally through replication of its successful strategies as part of the vanguard programme.

Key benefits

- Consistently safe and high quality nursing and social care in care homes
- Enhanced competence and confidence of care home staff.

29. Airedale & Partners

Using modern technology to enhance health in care homes

The vanguard is harnessing the full potential of modern technology called 'telehealth' or 'telemedicine' to improve the quality of life and end of life care for nursing and care home residents across Yorkshire and Lancashire.

The team has also been chosen by NHS England to spearhead the development of 'social movements' in health and care, with a focus on dementia.

The vanguard and the people it serves

The vanguard is led by doctors, nurses and other health and social care professionals from a partnership of organisations including three hospitals, four clinical commissioning groups, three councils, community healthcare providers, IT partners, numerous GP practices, GP networks and independent care home providers.

Its main focus is on the 7,687 residents living in 248 residential and nursing homes in Bradford, Airedale, Wharfedale, Craven and East Lancashire.

Contact: hannah.crossley@anhst.nhs.uk

What is changing?

New online technologies including live video links and health monitoring equipment are being used to give care homes direct access to support from healthcare professionals around the clock.

Known as telehealth or telemedicine, this easy to access, online support helps staff pick up and address any health issues as early as possible and deliver more specialist support into care homes.

A secure video link gives staff and patients immediate access to a 'hub' of senior nurses for advice and support, and the health professionals can monitor people on screen and make early decisions about any treatment needed.

The technology is now in place in 217 care homes across the vanguard, helping residents to remain active and independent – including those with breathing problems, heart conditions and dementia – and reducing hospital admissions, A&E attendance and GP visits.

The information technology partners in the vanguard are also developing a 'real-time' shared patient record so that all the health and care professionals working with a patient can see their up to date notes, supporting safer, quicker care.

In a separate part of the vanguard's work, the team is working with the Alzheimer's Society across local communities to improve health and wellbeing with a focus on dementia, looking specifically at getting serious about prevention of ill health, empowering people in their own health and care and engaging communities through actions such as volunteering.

Key benefits

- Improved support for care homes will reduce unnecessary hospital admissions and increase residents' independence
- Engaging local communities in better managing their own health will reduce reliance on health and care services.

The vanguards: urgent and emergency care

30. Greater Nottingham System Resilience Group

Helping people access the right urgent care service for them

Greater Nottingham will create an urgent and emergency care system where A&E is no longer the first or 'default' choice for patients, by helping them access other more appropriate urgent mental and physical health services in the community.

The vanguard and the people it serves

The vanguard partners include NHS Nottingham City, Nottingham West, Nottingham North and East, Erewash and Rushcliffe clinical commissioning groups; Nottingham University Hospitals NHS Trust; Nottinghamshire Healthcare NHS Foundation Trust; East Midlands Ambulance NHS Trust; Nottingham City Council; Nottinghamshire County Council; Nottingham CityCare Partnership; County Health Partnerships; Nottingham Emergency Medical Services (GP, Out of Hours); Derbyshire Health United (NHS 111) and Healthwatch Nottingham and Nottinghamshire.

This vanguard has a registered patient population of approximately 700,000.

Contact: nikki.pownall@nottinghamcity.nhs.uk

What is changing?

The vanguard will help people get the right advice in the right place, first time by making both urgent physical and mental health services easily accessible outside of hospital, so that people no longer choose to queue in the hospital emergency department.

All urgent and emergency care services will be better connected so that together, the physical, mental health and social care system delivers more efficient and improved care as a result.

This approach includes:

- Developing a clinical hub which will deliver an integrated urgent care pathway offering a viable alternative to A&E for patients;
- Supporting clinical navigation and referral of patients to appropriate settings offering an alternative to urgent hospital admission or direct admission into specialties without the patient going through A&E;
- Extending the clinical navigation service to include mental health; facilitating clinician to clinician communication to ensure patients are directed to the most appropriate support; and
- Providing primary care clinicians within A&E.

Key benefits

- A more efficient emergency and urgent care system will stop people automatically coming to A&E before considering other options, reducing patient frustration and waiting times
- An improved response for mental health problems will reduce the time taken to be seen by the right clinician in an appropriate place
- Adults and children with more serious or life threatening emergency needs receive timely treatment in centres with the right facilities and expertise.

31. Cambridgeshire and Peterborough Clinical Commissioning Group

Easy access to effective urgent care, seven days a week

Cambridgeshire and Peterborough Clinical Commissioning Group is working with local health partners to develop and improve local urgent and emergency health and care services.

As a part of the vanguard programme, the partners will accelerate improvements already underway and implement a best practice model for urgent care services. In particular, the vanguard aims to address variations in access to services and health inequalities in the region.

The vanguard and the people it serves

The partners include Cambridgeshire and Peterborough Clinical Commissioning Group; Cambridge University Hospitals NHS Foundation Trust; Peterborough and Stamford Hospitals NHS Foundation Trust; Hinchingsbrooke Health Care Trust; Cambridgeshire and Peterborough NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Papworth Hospital NHS Foundation Trust; Herts Urgent Care; Urgent Care Cambridge; East of England Ambulance Trust; Cambridgeshire County Council; Peterborough City Council; Cambridgeshire Crisis Care Concordat Board and voluntary and community sector organisations.

Together they serve a population of 922,000.

Twitter: [@fitforfuturenhs](https://twitter.com/fitforfuturenhs)

Contact: capccg.contact@nhs.net

What is changing?

Local urgent and emergency health services will provide safer, faster and better care for patients. The programme partners will change the way they work together to join up an often confusing range of A&E, GP services, minor injuries clinics, ambulance services, community services and the

NHS 111 non-emergency number so that patients know where they can get urgent help easily and effectively, seven days a week. This will include providing a 24/7 mental health crisis care service within the community that patients can access directly without needing a referral.

This work will be supported by the national team, which is helping the vanguard develop better joined-up commissioning (buying) and service delivery.

Plans include putting in place the right people to deliver the changes, including GPs, nurses, occupational and physical therapists, community pharmacists and other staff equipped to meet various mental and physical health needs.

The programme, which is being led by clinicians, is split into five workstreams:

1. NHS 111/out of hours clinical hub;
2. Admission avoidance/community access;
3. In-hospital emergency care;
4. Post hospital discharge; and
5. Mental health.

Key benefits

- Hospital, community, mental health and social care services to work more closely together to provide patients with safer, faster, and better care seven days a week
- Care will be delivered in, or as close as possible to, people's homes
- Patients will be treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

32. North East Urgent Care Network

Consistent urgent or emergency care, whatever the time or place

The North East Urgent Care Network is transforming the regional urgent and emergency care system to further improve consistency of care and clinical standards, by linking services together better and delivering high quality and responsive health and social care.

The vanguard and the people it serves

The vanguard partners include all the key physical health, mental health and care organisations in the region, which already have a strong history of working together.

They are the Academic Health Science Network; Clinical Health Information Network; Health Education North East; nine strategic resilience groups and associated members; North East Ambulance Service NHS Foundation Trust; north east local authorities; North of England Commissioning Support; regional out of hours providers; the Royal College of Psychiatry and the voluntary organisations' Network North East.

The network covers a population of 2.71 million across Northumberland, Tees, Esk and Wear Valley, Newcastle, Northumbria, Gateshead, Tyneside, Sunderland, County Durham, Darlington and Hartlepool.

Website: www.necsu.nhs.uk/about-us/partnership-zone

Contact:
necsu.urgentandemergencycarevanguard@nhs.net

What is changing?

The vanguard partners will work together to deliver consistent and seamless urgent and emergency care, wherever patients go for treatment and whatever the day or hour.

Patient experience will also be improved through a range of developments including direct booking of appointments through NHS 111, shorter waiting times and reduced duplication and 'handovers' to other services.

Families and carers will be included in the development of care plans which set out how individuals will be looked after, to increase their confidence and help ensure the patients' wishes are met.

There will also be improved support for anyone facing mental health crisis.

The network is involving staff in the design of these new ways of working and giving them opportunities to enhance their skills. They are also being given extra support when they need to make clinical decisions and more training to better understand mental health issues.

Key benefits

- Better joined up systems will improve the efficiency and cost effectiveness of urgent and emergency care
- The consistent and seamless care offered will improve patient experience, health and wellbeing.

33. Barking and Dagenham, Havering and Redbridge System Resilience Group

Changing the way people access urgent care

The Barking and Dagenham, Havering and Redbridge System Resilience Group is aiming to create a simplified, streamlined system of integrated urgent care, using the latest technology and advice to support people to get the right care in the right place, first time.

The vanguard and the people it serves

The vanguard partners include the Barking and Dagenham and Havering and Redbridge clinical commissioning groups; Barking, Havering and Redbridge University Hospitals NHS Trust; North East London NHS Foundation Trust; the London Boroughs of Barking and Dagenham, and Havering and Redbridge; Together First (Barking and Dagenham GP partnership); Havering Health (Havering GP partnership); Healthbridge Direct (Redbridge GP partnership); Partnership of East London Cooperatives; London Ambulance Service; the NHS England area team; Healthwatch and the local pharmaceutical committee.

This vanguard has a population of 750,000, living in one of the most challenged health economies in the country.

Website: www.bhrpartnership.org.uk

Twitter: @bhrpartnership

Contact: alansteward@nhs.net

What is changing?

Barking and Dagenham and Havering and Redbridge System Resilience Group's ambition is to radically transform local urgent and emergency care services, removing barriers between health and social care and between organisations.

We know that we need to do things differently and that patients are confused by the various urgent and emergency care services available to them – such as A&Es, walk-in centres, urgent care centres, GPs, pharmacists and out of hours services.

The variation and challenge across Barking and Dagenham, Havering and Redbridge makes us an ideal test bed for transforming urgent and emergency care services – if we can make it work here, we believe it could be replicated elsewhere in the country.

Our ultimate vision is for patients to access urgent care through modern digital technology – a 'click, call, come in' model that will recognise individuals and personalise the help they receive as soon as they get in contact.

Health and social care professionals will also be able to share and update patient care records, regardless of which setting patients are seen in.

Being a vanguard is allowing us to take significant steps towards achieving this vision, by testing innovations and building strong foundations for an effective and sustainable system of integrated urgent care.

This ambitious plan is being developed with patients and staff, and will build on existing successful partnership working between NHS and social care organisations locally.

Key benefits

- Better signposting to advice or support in the community will help reduce unnecessary hospital admissions
- Clicking or calling before they go to hospital will mean patients receive the right advice, first time in the right place.

34. West Yorkshire Urgent and Emergency Care Network

Delivering the five principles of improving urgent care

This vanguard's collective local vision is that everyone including children, young people and adults with urgent and emergency needs in West Yorkshire will get the right care in the right place, first time, every time.

The vanguard and the people it serves

The vanguard partners include 11 West Yorkshire clinical commissioning groups; five West Yorkshire system resilience groups, which include primary care and local authority partners; six NHS acute and community providers; three NHS mental health service providers; the local authority; Yorkshire and Humber Academic Health Science Network; West Yorkshire Healthwatch organisations; West Yorkshire Police; West Yorkshire Fire and Rescue Service; and the Yorkshire Ambulance Service.

The vanguard reaches a population of around 2.6 million people.

Website: www.healthyfutures.co.uk
Contact: andrea.willmott@attain.co.uk

What is changing?

This vanguard is building on a firm foundation of partnership working, shared learning and leadership to deliver the five principles set out in the national Keogh Urgent Care Review.

The vanguard will connect all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts. It will transform the services provided by local community and primary care and provide urgent acute and mental health services out of hospital where appropriate. This will mean providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people can get the right care in the right place, first time and no longer queue in hospital emergency departments.

The vanguard will also work to ensure that emergency medical centres have the facilities and expertise needed to provide the highest levels of care, with services working better together. This will ensure that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise to maximise their chances of survival and a good recovery.

There will also be a focus on self-care with individuals and communities provided with the support they need to better manage their own health and wellbeing.

Why are we doing this

Those with mental health problems have a different health and social care experience compared to other people receiving support. This is for a number of reasons, including the demand on mental health services, access issues, and patients being placed out of area. Children and young people are also unable to consistently access appropriate age related support.

This has resulted in people of all ages being held in police cells when an alternative setting would be better for them, and the inappropriate transportation of people via the ambulance service. There is also a move to clear pathways as defined through the Directory of Services.

Key benefits

- Better support for people to care for themselves or their families will reduce pressure on services and improve health and wellbeing
- Help for people who need urgent care to get the right advice in the right place, first time will reduce unnecessary visits to A&E
- Improved patient experience and access to services
- Safe closer to home support with a reduction in A&E attendances.

35. Leicester, Leicestershire and Rutland System Resilience Group

Easy and simple access to urgent care when people need it

This vanguard's vision is an integrated, coherent and intelligible urgent care system, with patients supported to access the right service via enhanced clinical navigation. Community urgent care services will be available 24 hours a day, seven days a week, with reduced duplication and improved information sharing and signposting between providers. Patients will be able to get the care they need without having to worry about finding their way around a complex and disjointed set of services.

The vanguard and the people it serves

The vanguard partners include Leicester City, East Leicestershire and Rutland and West Leicestershire clinical commissioning groups; three local authorities – Leicester City, Leicestershire County, and Rutland County; Arriva (patient transport service); University Hospitals of Leicester NHS Trust; East Midlands Ambulance Service; Leicestershire Partnership NHS Trust; Derbyshire Health United (NHS 111); and the Soldiers, Sailors, Airmen and Families Association (acute visiting services).

The vanguard covers a population of 1.1 million.

Twitter: @UrgentCareLLR

Contact: susan.venables@westleicestershireccg.nhs.uk

What is changing?

The vanguard will create an urgent and emergency care system where all the different services work together as one network. This will bring together ambulance, NHS 111, out-of-hours and other urgent services to ensure that patients get the right care, first time, including patients with mental health care needs. A clinical navigation hub will be piloted in October 2016, enabling patients who need a more skilled assessment to be warm transferred to clinicians working in the community.

The network will include a same-day response team including GPs, home visiting and crisis response services for people with urgent and acute health problems, community nursing, an older people's assessment unit and urgent care centres.

One of the vanguard partners, University of Leicester Hospitals NHS Trust, runs the largest single site accident and emergency department outside London. In April 2017, its urgent and emergency care 'front door' will be re-launched to include a streaming and assessment team. This team will refer patients who don't need a full emergency response to one of a range of alternative services including ambulatory clinics for people who can be easily treated without hospital admission, assessment beds for monitoring and tests, on-the-spot urgent care centres or their GP practice or local community care.

The vanguard is also developing a model to predict activity within urgent and emergency care, as well as increasing access for staff and patients to real-time data on waiting times. The aim is to improve planning within urgent and emergency care, allowing services to 'flex' during times of predicted increased activity, and to enable staff and patients to make decisions about the best urgent care option. For example, the public knowing the waiting time for each urgent or emergency care service before they decide the best place to go for support.

The work of the vanguard forms part of a five-year plan that all local commissioners and health and care providers have signed up to, and which aims to redesign the way that services are delivered across the whole local health and care system. This will include supporting and developing the workforce and building the infrastructure that allows them to deliver the best care.

Key benefits

- Patients can access urgent health and social care 24 hours, seven days of the week through enhanced clinical navigation, both via NHS 111 and a 'single front door' at Leicester Royal Infirmary
- Urgent mental health care needs will be given the same priority as physical ones, with the right staff and facilities in place.

36. Solihull Together for Better Lives

Supporting healthy, active and independent lives

The Solihull vision is to create a system where joined up health and care services support local people to have the best health and wellbeing possible, by preventing ill health, delivering care closer to home and offering rapid access to specialist services.

The vanguard and the people it serves

The partners include Heart of England NHS Foundation Trust (acute and community services); Birmingham and Solihull Mental Health NHS Foundation Trust; Solihull Metropolitan Borough Council; NHS Solihull Clinical Commissioning Group; voluntary and community sector providers; primary care (including the confederation of GP practices in Solihull); West Midlands Ambulance Service; West Midlands Police; West Midlands Academic Health Sciences Network; and lay members representative of service users, carers and the wider Solihull community.

The population in this area is 210,000.

Website: www.solihulltogether.co.uk

Contact: hkelly@nhs.net

What is changing?

The vanguard's ambition is to extend healthy active life and independence with an equal focus on physical and mental health and equal access to services.

The programme includes:

- A community wellbeing service – providing advice, support and equipment to help people stay healthy and independent for longer;
- An integrated primary and community care service – bringing together teams of community nurses, social care workers, mental health workers, geriatricians (doctors who specialise in care for older people) and local GPs; and
- An integrated urgent care service, including an ambulatory care service and integrated clinical hub to provide alternatives to hospital admission.

A new population-wide health information system will give the right health and care professionals access to an individual's full health and social care records. This will allow them to plan the person's care with them and address any health or wellbeing issues earlier.

The partners are using the support of the vanguard programme to build on these principles of care – initially designed for Solihull's frail and elderly – for the benefit of everyone in Solihull. By learning and sharing, and by engaging local communities, they hope to pioneer a new model to deliver care that is both better for patients and secures and modernises the local health and care system.

Key benefits

- Better coordination of services and self-management of long term health conditions will reduce pressure on hospitals
- Local people will live for longer in good health and with as much independence as possible
- Staff will feel empowered and equipped to do their jobs effectively.

37. South Devon and Torbay System Resilience Group

Quality and sustainability are key for future services

The urgent care system in South Devon and Torbay is being transformed to secure a sustainable future and a better quality of care. The vanguard aims to make the best use of local spending in urgent and emergency care, getting increased value for money by immediately identifying and avoiding any potential duplication in services.

The vanguard and the people it serves

The system resilience group includes Torbay and South Devon NHS Foundation Trust (an integrated care organisation created in October 2015 from the merged South Devon Healthcare Foundation Trust and Torbay and Southern Devon Health and Care Trust), together with South Devon and Torbay Clinical Commissioning Group, Torbay Council, South Western Ambulance Services Foundation Trust, Devon Doctors Ltd, and community pharmacies via the Local Pharmaceutical Committee.

This vanguard covers a population of 287,594.

Website:

www.southdevonandtorbayccg.nhs.uk/vanguard

Contact: ray.chalmers@nhs.net

What is changing?

The new model is based on five workstreams:

- Support for enhanced self-care (where patients are helped to better manage their own health)
- More joined-up urgent care, accessed via the NHS 111 phone number and supported by a new clinical hub which links services together
- New urgent care centres which will provide consistent, high quality services
- A mental health crisis response service for patients of all ages delivering 'parity of esteem' (equal priority) for mental and physical health
- Shared clinical/patient records.

The vanguard is taking advantage of the support offered by the national programme in two areas – harnessing technology, and integrating commissioning and provision.

Its 2016 priorities include developing at least two urgent care centre facilities, prioritising areas of higher deprivation. The vanguard will also share electronic primary care (GP) patient records with the out-of-hours provider and establish combined GP and Accident & Emergency (A&E)/urgent care centre facilities in at least two locations.

The 2017 priorities will include making all the planned urgent care centres available, with a predicted reduction in ambulance journeys to A&E of at least five per cent. Primary care (GP) services will also be available within all A&E/urgent care centre facilities.

Key benefits

- The public will better understand the alternatives to A&E for non-life threatening and emergency treatment
- Self-care initiatives helping people manage their own health will reduce the pressure on the overall health care system.

The vanguards: acute care collaborations

38. Salford and Wigan Foundation Chain

Creating a new model for an efficient healthcare group

Salford Royal and Wrightington, Wigan and Leigh NHS foundation trusts are leading the design of a healthcare group that will deliver improved clinical outcomes for their local populations.

This will take place against the backdrop of the devolution of health and care services across Greater Manchester from central government and NHS control (Devo Manc).

The vanguard and the people it serves

The vanguard is being led by Salford Royal NHS Foundation Trust and Wrightington, Wigan & Leigh NHS Foundation Trust, who together serve around two million patients.

Contact: raj.jain@srft.nhs.uk

What is changing?

The two foundation trusts involved in the vanguard are working with clinical commissioning groups (those organisations that plan and buy health and care services) and other health and care partners across the region to create a new healthcare group.

This group will create a new organisation that takes overall responsibility for health and care services, helping to increase the pace of improvements to care, which will result in better outcomes for their patients and more efficient ways of working.

Currently decisions are made on a hospital-by-hospital basis but the healthcare group model will mean that decisions about the best way to use resources can be made in response to the needs of the local population as a whole. This new process will also allow crucial decisions to be made at pace, delivering benefits quicker and more efficiently.

The trusts in the group will work to standard clinical, operational and workforce processes, removing any variation in the way patients are treated across the different trusts, and this will be supported by an investment in new IT systems to support joint working.

There will also be shared back-office (finance and human resources, for example) and clinical support services, and the group will work together on developing their workforces, whilst retaining the values and culture of the individual trusts.

Key benefits

- Reliable and consistent services will deliver an excellent patient experience and clinical care
- Working together, the benefits of service redesign and new ways of working will be realised quickly across a greater area.

39. Northumbria Foundation Group

Supporting partner trusts to offer consistent, high quality care

Northumbria Healthcare NHS Foundation Trust is planning to create the Northumbria Foundation Group to widen the support and services it can provide to other parts of the NHS. This will improve both cost efficiency and clinical effectiveness and ensure that high quality patient care is sustainable over the long term.

The vanguard and the people it serves

Northumbria Healthcare NHS Foundation Trust (Northumbria Healthcare) offers a range of services across health and social care, in hospital and community settings, as well as in people's own homes and serves a population of around 520,000.

Widely recognised as one of the country's top performing NHS foundation trusts and one of only five nationally to be rated outstanding by the Care Quality Commission, the Northumbria Foundation Group is being created to help the trust share its knowledge and expertise. It will support other NHS organisations across the country to help meet the challenges outlined in the NHS Five Year Forward View.

Website:

www.northumbriafoundationgroup.nhs.uk

Twitter: @NorthumbriaFG

Contact: claire.riley@northumbria.nhs.uk

What is changing?

By creating a high performing foundation group, Northumbria Healthcare aims to help share its knowledge and spread excellence, through a variety of flexible options such as consultancy and advisory services to other parts of the NHS.

Through the Northumbria Foundation Group, a range of clinical and corporate support services will be available, using proven best practice models to improve productivity and clinical effectiveness, with the ultimate goal of improving patient care and experience.

The vision is quite simply to create a more efficient and effective NHS by spreading expertise to improve quality of care, reduce costs and allow NHS organisations to reinvest in patient services.

Northumbria Foundation Group is focusing on being inclusive and working together across different organisations, ensuring it can support and work with a number of trusts at any point in time. Group members will be able to choose from a range of membership options, all designed to help them work more closely together with other group members and partners to spread learning and innovation. Other initiatives are also being brought in to help support this new way of working, such as systems to share electronic patient information.

The team is also looking to further develop the use of telehealth (equipment which is used to monitor patients' health remotely) and teleconsultation (e.g. video conversations between patients and health professionals), as well as apps, to help group members and their patients to effectively manage and monitor long term conditions and treatment plans.

The Northumbria Foundation Group will continue to watch and learn from examples of best practice being delivered around the world in order to further develop and enhance the foundation group in the future.

Key benefits

- Spreading innovation and best practice across the NHS
- Developing consistently high quality services and better management of long term conditions across the group will improve the health and wellbeing of local people
- Improved standards of care and reduced variation will help reduce health inequalities
- By working together through shared clinical networks or services, the group will become more cost effective and efficient.

40. Royal Free London

Leading the way for hospitals to work better together

The Royal Free London NHS Foundation Trust believes that significant improvements in patient health outcomes and patient experience, as well as cost savings, can be achieved by creating hospital groups, which bring a number of hospitals together, connected by a single group centre. It proposes to create a group of between 10 and 15 NHS trusts, serving around five million patients. Individual organisations will be able to join the group under a range of 'membership options', from full membership (where the member is fully owned) to 'buddying'.

The Royal Free London is leading one of the 13 vanguards in the new care models programme designed to spread excellence in hospital services and management across different areas and organisations and explore radical new options for the future of hospitals across the NHS.

The vanguard and the people it serves

The population which is served by this vanguard will depend on which partners join the proposed group.

Contact: caroline.clarke@nhs.net

What is changing?

The trust wants to find ways to improve the quality of patient care while also reducing the cost to the healthcare economy as a whole.

They are considering various options including merging some office functions (such as human resources) as well as innovative new ways for clinicians to work together.

The trust is receiving financial and practical support from the new care models national team to develop this work.

Key benefits

- Improved patient health
- Increased efficiency and reduced costs
- A more engaged and higher skilled workforce
- Creation of a national template for this new way of working that can be adapted or replicated across the country.

41. Foundation Healthcare Group (Dartford and Gravesham)

A new way of linking organisations to offer improved care

Dartford and Gravesham NHS Trust and Guy's and St Thomas' NHS Foundation Trust are exploring the option of linking up to create a Foundation Healthcare Group. By forming this kind of group, the two trusts will be able to work together more closely in a planned way to improve care, without the formal organisational change of a merger or acquisition.

The vanguard and the people it serves

Dartford and Gravesham NHS Trust provides a full range of local hospital services for people living in North Kent and Bexley, south east London. The Trust works with partners to provide a range of specialist services locally and offers a number of regional services including stone and kidney care. The Trust has a rapidly increasing population due to local housing developments in Dartford and the development of a Healthier New Town in Ebbsfleet.

Guy's and St Thomas' NHS Foundation Trust provides a full range of local hospital and community services for people living in the south London boroughs of Lambeth and Southwark. The Trust also provides specialist care for patients from further afield, including cancer and cardiothoracic services. Evelina London Children's Hospital at St Thomas' provides general and specialist services for children from London, south east England and further afield.

The Foundation Healthcare Group aims to enhance the standard of care our patients receive, patient outcomes and their experience. To achieve this, the group will improve the sustainability of local services by working more effectively together, sharing learning and standardising practice.

Contact: dgn-tr.vanguardfhg@nhs.net

What is changing?

The two trusts are using the funding and expertise offered by the national support team for vanguards to assess the options they have for linking up more closely without needing to go through the expense and upheaval of becoming a single organisation.

The two trusts want to work together as the Foundation Healthcare Group to create local, sustainable services that will help them offer consistently better care for patients; delivered locally where possible and in a more cost effective way.

By working in closer partnership, the trusts will make best use of scarce resource in ways that others across the NHS can learn from and replicate.

They will do this by:

- Sharing resources to enable them to meet the challenge of more and more demand for NHS services whilst also becoming more financially sustainable;
- Reducing differences in the care that patients receive across the two trusts;
- Sharing information and knowledge, and supporting teams to work more closely together and share their resources; and
- Giving staff more opportunities to learn new skills and deliver better care for patients.

Key benefits

- More and better quality care available for patients close to home
- Better value for money for the NHS
- Consistent, high quality care for all patients.

42. Moorfields

Developing a clear vision to share with others

Moorfields Eye Hospital NHS Foundation Trust is seeking to understand whether the longer term sustainability of single speciality services in smaller hospitals can be strengthened by entering into a network partnership, and the benefits that might bring. To do this the trust is learning from its own experience of delivering a single speciality service across multiple sites, from other organisations using a networked model of care to deliver services and from the smaller hospitals which may face sustainability challenges.

The vanguard and the people it serves

This vanguard, led by Moorfields Eye Hospital NHS Foundation Trust, has a national and international reach through its collaboration with other NHS providers, non-NHS healthcare providers and networks from other sectors.

Contact: karen.reeves@moorfields.nhs.uk

What is changing?

The trust is keen to learn what makes the biggest difference for patients, staff and partner organisations in getting things right first time when establishing a service in a new setting and to identify the best way to build and sustain a care model that will allow a provider to successfully offer specialist care across a number of locations as a network solution.

They will use this learning to produce a 'toolkit' with evidenced based learning which other trusts can use to evaluate whether a networked model of care is the right strategic fit for future sustainability. The toolkit will also have practical advice and guidance to enable other organisations to establish their own network in the way best suited to local circumstances.

Moorfields already runs services in 32 locations in and around London in a variety of healthcare settings but these were developed separately in response to individual needs, aiming to move care closer to home or support sustainability of ophthalmology (eye care) in local hospitals. The aim now is to help develop future networks in a planned way and quickly, sharing good practice across the wider NHS and understanding the opportunities and risks of this way of working.

Key benefits

- Learning will be shared across a range of specialties, not just eye care
- By evidencing the benefit of networking care, more patients will be treated for more of their care closer to home.

43. National Orthopaedic Alliance

Supporting specialty services to improve quality across the country

Orthopaedic services support patients who have problems with their bones, joints or ligaments. The National Orthopaedic Alliance wants to improve the services that its members provide and then create a framework (or 'pathway') that others can follow to improve their own care standards, leading to consistent high quality care across the whole country.

The vanguard and the people it serves

Founding partners include Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in Oswestry; Royal National Orthopaedic Hospital NHS Trust in Stanmore and Royal Orthopaedic Hospital NHS Foundation Trust in Birmingham.

This vanguard has a national reach.

Contact: rachelyates@nhs.net

What is changing?

The vanguard is aiming to improve the quality and consistency of orthopaedic care for patients across the country and in doing so, develop a new way of working that smaller hospitals and specialist providers can introduce to help them offer services that are better quality and more consistently cost-effective.

Through their work to improve their own services, the vanguard partners will create tools that other providers can use to offer high quality, efficient services. They will also set the quality standards that should be met across other providers.

As well as looking at how orthopaedic services are delivered to patients, they will develop new business and funding models and new ways for organisations to work more closely together. This will include 'back office' functions such as finance and human resources as well as the clinical teams.

The National Orthopaedic Alliance will also further develop the concept of 'franchises' in the NHS, where specialist trusts agree to oversee and guide other hospitals delivering certain specific services. For example, a local hospital could ask orthopaedic surgeons from a specialist trust to offer clinics from their site to help bring care closer to home for patients.

Their model for franchising in the NHS could then be used by other specialties to help spread their services across a wider area.

Key benefits

- Supports the spread of specialist care over wider areas, bringing care closer to home
- Improves both the efficiency and effectiveness of services, leading to a better quality of care and long term financial sustainability.

44. The Neuro Network (The Walton Centre, Liverpool)

Working as a network to sustain the delivery of local specialist care

The work being planned by The Neuro Network will enable patients across Cheshire and Merseyside to have rapid access, locally, to high quality neurology and spinal services from a regional specialist centre.

The vanguard and the people it serves

The Neuro Network is a partnership which sees The Walton Centre NHS Foundation Trust (the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, rehabilitation, neurosurgery, spinal and pain management services) work with other NHS providers and commissioners to improve care for neurology and spinal patients and those with back pain. Warrington and Halton Hospitals NHS Foundation Trust; Liverpool Clinical Commissioning Group; Warrington Clinical Commissioning Group and the NHS England Specialised Services Commissioning Team (North) are part of The Neuro Network with more partners anticipated to join as the programme is rolled out across the Cheshire and Merseyside area.

The vanguard covers a population of three million.

Contact: julie.riley@thewaltoncentre.nhs.uk

What is changing?

The programme will build on the vanguard partners' extensive history of working together in networks to deliver neurology (help for problems within the nervous system) and spinal services.

The Walton Centre will work closely with other hospitals, GPs and community services to improve the quality of care and reduce variations in standards, ultimately benefiting patients with neurology and spinal conditions. It already provides neurology services at district general hospitals across Cheshire, Merseyside, Cumbria and North Wales, holding clinics and helping look after patients on the wards. The vanguard will use the national support available to develop joint working further across Cheshire and Merseyside.

The aim is to deliver improved results for patients and better use of resources within the local Merseyside and Cheshire area, as well as strengthening the acute support available in hospitals on a seven-day basis.

This way of working across a network is one that can be followed across the NHS as a whole to benefit patients nationally. It is recognised that there are too few consultant neurologists to provide a self-sufficient service in every district general hospital, and working together in this way allows local care to be available while still using resources efficiently and effectively.

The team is planning to establish a spinal network to further improve services for patients' spinal conditions, increase the specialist support and advice currently given to GPs and local hospitals.

The Neuro Network will also standardise care for patients with back pain. At present, treatment can be inconsistent and patients often experience significant delays in getting the right care for their needs.

There is currently considerable variation in the surgery that is offered, and this will be addressed through different services working together as a regional spinal network for both urgent and planned spinal surgery, closing a gap in care and quality. As well as the benefits the vanguard work will bring for patients, staff will benefit thanks to the opportunities it offers for engaging in innovative service development. This will include using modern technology within their working environment and the chance to undertake new roles such as the advanced neurology nurse posts that are being developed.

Key benefits

- Earlier diagnosis and treatment will allow more effective management of long term neurological or spinal related conditions
- Services working together as a network will ensure equal access to consistent, high quality care
- Provision of care closer to home.

45. MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) (West Midlands)

Sharing best practice to transform acute mental health care

A mental health trust alliance to transform acute care in the West Midlands.

This vanguard aims to share best practice and create new ways of working for specialist mental health services that are more effective, efficient and offer consistent value for money.

The vanguard and the people it serves

The vanguard partners include Birmingham and Solihull Mental Health NHS Foundation Trust; Black Country Partnership NHS Foundation Trust; Dudley and Walsall Mental Health Partnership NHS Trust; and Coventry and Warwickshire Partnership NHS Trust.

Together they cover a population of 3.4 million.

Twitter: @MERITvanguardwm
Contact: merit.vanguard@nhs.net

What is changing?

MERIT will focus on three priority areas to address the greatest challenges faced by urban mental health services – crisis care and reduction of risk, recovery and rehabilitation, and every day services.

The vanguard partners will aim to rapidly improve service quality and increase efficiency by working better together to provide a consistent service that takes into account local needs, reduces variations in care and spreads best practice.

Service users will benefit from a co-ordinated emergency response and faster decision making (for example, it will be possible to discharge people seven days a week rather than only on week days). Their care plans will also be shared by all the health professionals involved in their care, so that they only need one assessment and to tell their story once.

The vanguard will also provide more support for recovery in the community, to reduce the chance of service users becoming unwell again and limit the unnecessary time spent in A&E or police cells.

If inpatient care is needed, this will be managed centrally to maximise availability and increase flexibility across the four trusts, meaning service users are more likely to stay closer to home if a bed is not available in their immediate area.

Key benefits

- More community support will reduce avoidable hospital admissions
- Inpatient care closer to home
- More efficient services will offer better value for money for the NHS
- Better sharing of information and expertise
- More flexible workforce across the West Midlands
- Recovery models which aim to prevent relapse or readmission back to secondary care.

46. Cheshire and Merseyside Women's and Children's Services

Addressing the challenges together

This vanguard is aiming to develop a network for women's and children's services (including maternity, gynaecology, neonatal and paediatric services) across Cheshire and Merseyside to further improve quality and value for money to ensure services can be delivered in the long term.

The vanguard and the people it serves

The work has the backing of all provider trusts, clinical commissioning groups and health networks across Cheshire and Merseyside.

These include:

- Providers: Alder Hey Children's Hospital; Bridgewater Community Healthcare; Countess of Chester Hospital; Liverpool Women's; Mid Cheshire Hospitals; North West Ambulance Service; Southport and Ormskirk Hospital; St Helens and Knowsley Teaching Hospitals; Warrington and Halton Hospitals; and Wirral University Teaching Hospital
- Commissioners: the CCGs for Halton; Knowsley; Liverpool; St Helens; South Cheshire; South Sefton; Southport and Formby; Vale Royal; Warrington; West Lancashire; Wirral; West Cheshire; West Lancashire; plus NHS England
- Health networks: Cheshire and Merseyside Maternity; Children and Young People Strategic Clinical Network; North West Neonatal Operational Delivery Network and Adult Critical Care Operational Delivery Network.

2.4 million people could benefit from the work of this vanguard.

Contact:

catherine.mcclennan@haltonccg.nhs.uk

What is changing?

The vanguard is addressing the challenges facing services for women and children locally by creating a new approach between commissioners (those organisations that plan and buy services), clinicians and providers that goes beyond organisational boundaries.

These challenges include a greater demand for services and an increase in patients with more complex needs as well as variation in quality of services. No single organisation, commissioner or provider working alone can resolve these issues and this vanguard will also enable organisations to work together to tackle challenges around workforce like recruitment, retention, retirement and the skills available in the workforce, as well as overall financial sustainability.

In addition, the vanguard is engaging more with the people who use services, so it can better understand their needs and create more personalised or targeted support, improving health and wellbeing.

Key benefits

- Working together better will create a more effective and efficient health and care system, in terms of both quality of care and value for money
- Engaging more with local people will help them better manage their own health.

47. Accountable Cancer Network (ACN)

Working together to offer the best cancer care available

The overarching aim of the cancer vanguard is to ensure everyone receives high quality cancer care when and where they need it. It is a partnership of three organisations: The Christie NHS Foundation Trust, The Royal Marsden NHS Foundation Trust (RM), and University College London Hospitals NHS Foundation Trust (UCLH). It was established to pilot new models of cancer care across London and Manchester to improve the rates of earlier diagnosis and detection, improve patient outcomes and experience and reduce variation.

The vanguard and the people it serves

The vanguard serves a population of over 10 million people, providing it with a unique opportunity to develop new ways of working that provide replicable models for cancer care that can be reproduced nationally.

Website: www.cancervanguard.nhs.uk
Contact: executive.assistant@rmh.nhs.uk

What is changing?

This vanguard was established to help deliver high quality, patient centred and financially sustainable cancer care. It will also work to deliver certain recommendations in the national cancer strategy Achieving World-Class Cancer Outcomes – A Strategy for England 2015-2020.

Each of the vanguard partners leads a local delivery system – Greater Manchester Cancer Vanguard, RM Partners in north west and south west London, and UCLH Cancer Collaborative covering west Essex, north central and north east London – which comprises health organisations in their area, including clinical commissioning groups, NHS acute trusts, community services and hospices.

The vanguard will deliver a coordinated, whole system approach to cancer care, looking at prevention and education as well as early diagnosis and treatment. It will work to improve the care of those living with and beyond cancer, as well as palliative and end of life care.

Hospitals, GPs and commissioners have all had input into how the cancer vanguard operates, and will continue to do so. More importantly, throughout the process patients, their families and carers have been at the heart of the design of the vanguard and will be meaningfully involved at every state in shaping this new system of cancer care.

Key benefits

- Shifting emphasis towards prevention and earlier diagnosis has the potential to dramatically improve patient outcomes
- Working together across a network will ensure that resources are used more efficiently and enable clinicians to provide patients with the best cancer care available.

48. EMRAD - East Midlands Radiology Consortium

Linking radiology services to improve support for clinical colleagues

Seven NHS trusts across the East Midlands are creating a clinical network which will deliver timely and expert radiology (such as X-ray services) for patients regardless of where they are treated. Once developed, this network will set a national standard for other NHS radiology services to follow.

The vanguard and the people it serves

The EMRAD consortium is hosted by Nottingham University Hospitals NHS Trust and also includes the Chesterfield Royal, Kettering General Hospital and Sherwood Forest Hospitals NHS Foundation Trusts, and Northampton General Hospital, United Lincolnshire Hospitals and University Hospitals of Leicester NHS trusts.

Together they cover a population of around six million.

Website: www.emrad.org

Twitter: @emradNHS

Contact: tim.taylor@nuh.nhs.uk

What is changing?

The EMRAD network and the new ways of working that are planned will significantly improve the clinical care offered within urgent services such as major trauma and stroke and in regional acute surgical centres, as well as improving the support available to smaller hospitals and outpatient facilities around the region.

A new shared technical system will allow clinicians to access the complete radiology imaging record for their patients (including scans, reports and clinical opinions), regardless of where they are based, which will help more clinicians provide more care closer to patients' homes.

The network will also allow the trusts involved to develop regional services that can help bring work back into the NHS which is currently being delivered in other sectors, and to support both large and small trusts through the formal sharing of expertise.

Key benefits

- Improved support for clinicians who need to use scan results to make decisions on patient care (such as A&E teams) will allow them to deliver the best care
- The network supports the aim of providing more care closer to home by making test results available to all appropriate clinicians, wherever they are based.

49. Developing One NHS in Dorset

A focus on sustainable, seven day services for all

The vision in Dorset is one of effective and affordable models of care for hospital and community care that meet the needs of local people 24 hours a day, seven days a week.

As an acute care collaboration vanguard, the three district hospital providers in Dorset are aiming to work together as a 'multi-service joint venture' to deliver this vision and ensure the future sustainability of health services across the region.

The vanguard and the people it serves

The vanguard partners are three NHS organisations: Dorset County Hospital NHS Foundation Trust, Poole Hospital NHS Foundation Trust, and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Together they serve a patient population of 766,000.

Contact: onenhsindorset@poole.nhs.uk

What is changing?

Clinical networks of health professionals and service teams are being developed to ensure that all patients have faster and equitable access to a consistent, high standard of care, irrespective of where they live.

The aim is to ensure patients' needs are placed before those of organisations, while at the same time offering better value for money and contributing to financial sustainability for Dorset and the wider NHS.

As well as a reduction in avoidable variations in care, there will also be wider implementation of the same best practice and more sharing of service innovation.

The national vanguard support team is also offering expertise and guidance to the partnership in delivering the workforce developments needed to implement the new clinical models. This includes a potential movement to a single shared rota across the county for some clinical services to ensure the best use of senior clinicians. 'Job plans' are also being developed to support the recruitment and retention of high calibre clinicians.

Key benefits

- Hospital providers work and develop services together to provide the best patient services
- More support for seven day working
- Better health outcomes for patients.

50. Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)

Making improvements together that can't be done by acting alone

The overall vision of the Working Together vanguard is to be one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems by 2020.

Working together on a number of common issues, this partnership aims to strengthen each organisation's ability to deliver safe, sustainable and efficient local services and improve the health and wellbeing of local people.

The vanguard and the people it serves

The Working Together Programme is a partnership between seven acute hospital trusts in South Yorkshire; Mid Yorkshire and North Derbyshire – Barnsley; Chesterfield Royo; Doncaster and Bassetlaw; Mid Yorkshire; Rotherham; Sheffield Children's; and Sheffield Teaching Hospitals. It was established in March 2013.

Together the trusts cover 15 hospital sites with approximately 45,000 staff, serving a population of approximately 2.3million.

Website: www.workingtogethernhs.co.uk

Twitter: @WTPVanguard

Contact: janettewatkins@nhs.net

What is changing?

The trusts will work together and on a larger scale to improve patient safety and care and to make systems more efficient in ways which any individual organisation would not be able to achieve by acting alone.

By sharing collective expertise and knowledge, they will improve quality, safety and patients' experience of the care system.

Services will reduce the variation in care quality for patients by sharing best practice to learn from each other, and developing the same new ways of working.

Patient information systems will be joined up across the organisations to improve safety and patient experience.

The trusts also hope that by developing innovative new ways of working, they will help hospital specialities recruit and retain specialist staff.

Key benefits

- Safe and sustainable new models of care
- Organisations working together to make savings where they can.

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The new care model vanguards are delivering real change for patients and staff. Working with clinicians and the people who use their services, they are developing a blueprint for the future of NHS and care services across England. They're being led locally, but with national support to help them move forward at pace and to unlock barriers that get in their way.

”

Samantha Jones

Director - New Care Models Programme

@SamanthaJNHS

For more information visit:
www.england.nhs.uk/vanguards

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